Supreme Court, U.S.
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No. _____

In the
Supreme Court of the United States

MINNESOTA SENIOR FEDERATION, METROPOLITAN REGION; and MARY SARNO,

Petitioners,

v.

UNITED STATES OF AMERICA; and TOMMY G. THOMPSON, Secretary of Health and Human Services,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Does the burden and deterrent effect of a *federal* statute on interstate travel and relocation implicate the constitutional right of citizens to travel and relocate from state to state – making the statute subject to careful judicial scrutiny – only if, as the Court of Appeals held in this case, one of the three situations described in Saenz v. Roe, 526 U.S. 489 (1999), applies?

PARTIES TO THE PROCEEDING

The Petitioners are the Minnesota Senior Federation, Metropolitan Region, and Mary Sarno, plaintiffs in the action in the District Court, *State of Minnesota, et al. v. United States of America, et al.,* No. 99 Civ. 1831 (D. Minn.).

The Respondents, defendants in the District Court, are the United States of America and Tommy G. Thompson, Secretary of Health and Human Services. During appellate proceedings, Respondent Thompson was substituted as a party under Fed. R. App. P. 43(c)(2) for Donna E. Shalala, the former Secretary of Health and Human Services named as a defendant in plaintiffs' complaint.

The State of Minnesota, by its Attorney General, Mike Hatch, also was a plaintiff in the action in the District Court. However, the District Court dismissed the State's claims, and the State did not appeal from the order and judgment of dismissal.

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Petitioners Minnesota Senior Federation and Mary Sarno respectfully pray that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Eighth Circuit entered in this matter on December 13, 2001.

OPINION AND ORDER BELOW

The opinion of the United States Court of Appeals for the Eighth Circuit, affirming the District Court's order dismissing plaintiffs' claims, was filed on December 13, 2001, and is reported at 273 F.3d 805 and reprinted as Appendix A hereto.

The order of the United States District Court for the District of Minnesota dismissing plaintiffs' claims, was entered on July 6, 2000, and is reported at 102 F. Supp. 2d 1115 and reprinted as Appendix B hereto.

STATEMENT OF JURISDICTION

Jurisdiction of this action in the District Court was based on 5 U.S.C. § 702 and 28 U.S.C. §§ 1331 and 1346. Jurisdiction in the Court of Appeals was based on 28 U.S.C. § 1291. This petition for a writ of certiorari seeks review of the judgment of the United States Court of Appeals for the Eighth Circuit entered December 13, 2001. Jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

CONSTITUTIONAL PROVISIONS AND STATUTES INVOLVED

The Supreme Court has cited several constitutional provisions as the basis of the right to travel and relocate, including the Commerce Clause of Article I, the Privileges and Immunities Clause of Article IV, the Due Process Clause of the Fifth Amendment, and the Equal Protection and Privileges and Immunities Clauses of the Fourteenth

Amendment, as well as concepts of personal liberty and principles of federalism. This case also involves the following provisions of the United States Code: 42 U.S.C. §§ 1395w-21 to w-28, 42 U.S.C. § 1395mm(a)-(g), and 42 U.S.C. § 1395ss(s), which are set forth in Appendix D.

STATEMENT OF THE CASE

A. Procedural History

On November 17, 1999, the State of Minnesota, Minnesota Senior Federation, and Mary Sarno filed an action against the United States and the Secretary of Health and Human Services in the United States District Court for the District of Minnesota, *State of Minnesota, et al. v. United States of America, et al.*, No. 99 Civ. 1831 (D. Minn.). Jurisdiction was based on 5 U.S.C. § 702 and 28 U.S.C. §§ 1331 and 1346.

Plaintiffs' complaint alleges that the reimbursement system for managed care provided by health maintenance organizations ("HMOs"), part of the federal Medicare program, produces substantial and persisting geographic disparities in benefits that impose a burden upon and deter and penalize the exercise of the constitutional right of senior citizens to travel and relocate from state to state. Plaintiffs' complaint also alleges that the Medicare managed care reimbursement system violates the constitutional right of senior citizens to equal protection of the law for lack of rational relationship to the stated purpose of expanding health care delivery options and containing costs. Plaintiff State of Minnesota further alleged that the payment formula violates the principle of nondiscrimination among sovereign states in the federal system by producing substantial funding disparities among states and causing the State to incur increased costs in meeting the health care needs of its senior

citizens. The plaintiffs seek a declaratory judgment that, in its present form, the Medicare managed care funding system is unconstitutional and an order enjoining the managed care reimbursement system of Medicare+Choice, the Medicare Part C program adopted in 1997.

Defendants moved to dismiss plaintiffs' complaint for failure to state a claim on which relief can be granted pursuant to Fed. R. Civ. P. 12(b)(6). On July 6, 2000, the District Court entered an order granting the motion to dismiss and directing entry of judgment dismissing all of plaintiffs' claims against both defendants. Judgment was entered the same day.

Plaintiffs Minnesota Senior Federation and Mary Sarno appealed from the judgment of dismissal to the United States Court of Appeals for the Eighth Circuit. Jurisdiction was based on 28 U.S.C. § 1291. Plaintiff State of Minnesota did not appeal from the dismissal of its claims. On December 13, 2001, the Eighth Circuit Court of Appeals issued its decision affirming the judgment of dismissal.

B. Statement of Facts

Mary Sarno, a senior citizen and Medicare managed care participant, resides in Broward County, Florida. Her daughter lives in Minnesota. Sarno would like to move to Minnesota but cannot do so because Medicare managed care coverage in Minnesota provides substantially fewer health care benefits than the coverage provided by her Medicare HMO in Florida. Minnesota Medicare HMOs not only provide fewer benefits, but also require their enrollees to pay for parts of the benefits they do provide. See Complaint at ¶ 9 (App. C–4-5). In Minnesota, Sarno and her husband would have to pay approximately $800 a month for prescription drugs, items fully covered by her Florida Medicare HMO. She also would

have to pay substantial monthly health insurance premiums and numerous co-payment charges that she does not pay in Florida. See Complaint at ¶ 9 (App. C–4-5). The prospect of thousands of dollars of additional annual health care expenses deters Sarno from moving to live with her daughter in Minnesota. The disparities in benefits that prevent and would penalize her move are a direct result of the Medicare HMO funding system adopted and administered by the defendants.

1. Background

Medicare, the national health insurance program for elderly and disabled persons, was established in 1965 as part of the Social Security Act. It is the nation's largest health insurance program and has nearly forty million participants. Benefits traditionally provided by Medicare fall into two categories. Medicare Part A provides a nationally-uniform set of institutional health care benefits, mainly inpatient hospital care. Part A benefits are paid from the Medicare Trust Fund, which is funded by uniform payroll taxes on employers, employees, and the self-employed. Medicare Part B provides a nationally-uniform set of supplemental benefits, including physicians' services, laboratory services, medical equipment, and other non-institutional medical services. Participation in Part B is voluntary, and benefits are funded from general federal tax revenues and from uniform monthly premiums paid by participating beneficiaries. Under both Medicare Part A and Part B, benefits are provided by fee-for-service reimbursement, under which health care providers are paid for each service provided to a beneficiary. See Complaint at ¶¶ 12-13 (App. C–5-6).

Prior to 1997, Section 1876 of the Social Security Act permitted an HMO providing Medicare benefits to enter a contract to receive payments on either a cost basis or a risk basis. See Complaint at ¶ 15 (App. C-6). Under cost-basis

contracts, a Medicare HMO received its actual costs incurred in providing managed care benefits. Under risk-basis contracts, a Medicare HMO received a monthly capitation payment for each enrollee based on the adjusted average per capita cost of providing benefits ("AAPCC"). The AAPCC was an estimate of the average per capita cost of treating a particular beneficiary under the fee-for-service system and took into consideration the beneficiary's county of residence and certain other demographic characteristics, such as age, sex, and disability status. See 42 U.S.C. § 1395mm(a)(4). For each Medicare beneficiary enrolled, the HMO was paid 95% of the AAPCC rate corresponding to the demographic class to which the beneficiary was assigned. See 42 U.S.C. § 1395mm(a)(1)(C).

AAPCC rates have differed greatly from state to state. For example, in 1997, the AAPCC rate for Dakota County, Minnesota, was $356.24, the rate for Richmond County, New York, was $767.35, and the rate for Dade County, Florida, was $748.23. In 1997, every county in Minnesota had an AAPCC rate below the national average. See Complaint at ¶ 19 (App. C-7).

Under Section 1876 of the Social Security Act, Medicare HMOs with risk-basis contracts were obliged to absorb any costs incurred that were higher than the AAPCC rate. However, if the actual premium the HMO would charge a private participant (the HMO's Adjusted Community Rate or "ACR") was lower than the AAPCC rate, the HMO had the option of passing on to its enrollees the "savings" or "excess" in the form of reduced co-payments or additional health care benefits not covered by Medicare, such as prescription drugs, eyeglasses, and hearing aids. The HMO also had the options of receiving lower monthly capitation payments or contributing all or part of the excess to a stabilization fund. See 42 U.S.C. § 1395mm(g)(2)-(3). Most HMOs chose to use

any excess to increase the benefits provided to their enrollees. See Complaint at ¶ 22 (App. C-8).

2. The 1997 Amendment

In 1997, Congress added Sections 1851 through 1859 to the Social Security Act, 42 U.S.C. §§ 1395w-21 to w-28, to establish a new Part C of the Medicare program, known as Medicare+Choice. The stated purpose of Medicare+Choice was to "allow beneficiaries to have access to a wide array of private health plan choices in addition to traditional fee-for-service Medicare. . . [and to] enable the Medicare program to utilize innovations that have helped the private market contain costs and expand health care delivery options." See H. Conf. Rep. No. 105-217, at 585 (1997), reprinted in 1997 U.S.C.C.A.N. 176, 205-06.

In enacting Medicare+Choice, Congress also intended to reduce the substantial geographic disparities in payments to Medicare HMOs by modifying the capitation method used to pay HMOs receiving payments on a risk basis. See 42 U.S.C. § 1395w-23. Under Medicare+Choice, capitation rates are the greater of:

1. a "blended" capitation rate, taking into account both the local, area-specific Medicare costs on which the old AAPCC rates were based and national costs (capped by a budget neutrality factor and phased in incrementally over six years);
2. a minimum monthly payment, which in 1998 was $367; or
3. a minimum percentage increase of 2% over the previous year's AAPCC capitation rate.

See 42 U.S.C. § 1395w-23(c)(1).

While the new formula appeared to address the geographic inequity of the managed care funding system, it did not have that effect. The Medicare+Choice formula did not abandon the old AAPCC rates; the differences in those rates were perpetuated. And, because of a "payment adjustment budget neutrality" restriction, aggregate payments to Medicare HMOs were effectively capped. With a fixed number of dollars available, every extra benefit given to Medicare HMO beneficiaries in high reimbursement areas (those with high AAPCC rates) has had to come directly from benefits that otherwise would have been given to Medicare HMO participants in low-reimbursement areas.

Thus, under the Medicare+Choice HMO reimbursement system adopted in 1997, state-to-state funding and benefits disparities persisted and, in fact, worsened. Plaintiffs Minnesota Senior Federation and Sarno thus allege that:

- [I]n 1997 the reimbursement level for HMOs serving Hennepin County, Minnesota, residents was $405.63 per member per month, while the reimbursement level for HMOs serving residents in Richmond County, New York, was $767.35 per member per month, a difference of $361.72. Under the [new reimbursement system] both counties received a 2% increase for 1998. This increased the reimbursement rate in Hennepin County to $413.74 . . . and increased the Richmond County, New York, reimbursement rate to $782.70. The result was to widen the gap between these illustrative counties to a $368.96 difference.

- [I]n 1999, the Medicare managed care monthly reimbursement rate for Dakota County, Minnesota, was $394.92. By comparison, the 1999 reimbursement rate for Broward County,

> Florida, was $676.64; for Los Angeles County, California, $647.70; and for Dade County, Florida, $778.45.

See Complaint ¶ 27; (App. C–10-11).

Under the Medicare+Choice reimbursement system, as under the previous Section 1876 risk-basis contracts, a Medicare HMO with an AAPCC higher than its Adjusted Community Rate ("ACR") (the actual premium the HMO would charge to a private participant) can offer additional benefits to its enrollees. See 42 U.S.C. § 1395w-24(f)(1). As a result, substantial differences persist in the types and amounts of benefits provided to Medicare HMO participants in different parts of the country. For example, at the time this action was filed, two otherwise-identical Medicare HMO enrollees, one living in Broward County, Florida, and one living in Dakota County, Minnesota, received very different Medicare HMO benefits, as set forth in the following table:

Minnesota Medicare HMO Enrollee		**Florida Medicare HMO Enrollee**	
Annual Premium	$1,137	Annual Premium	0
Physician Visit Co-Payment	$10	Physician Visit Co-Payment	0
Prescription Drugs	Not Covered, except insulin	Prescription Drugs	100% Covered
Ambulance Transp. Serv. Co-Payment	0 in area 20% out-of-area	Ambulance Transp. Serv. Co-Payment	0
Mental Health Session Co-Payment	$10	Mental Health Session Co-Payment	0

Minnesota Medicare HMO Enrollee		Florida Medicare HMO Enrollee	
Emergency Service Co-Payment	$30	Emergency Service Co-Payment	0
Urgent Care Service Co-Payment	$30	Urgent Care Service Co-Payment	0

See Complaint at ¶¶ 31-39 (App. C–12-13). Such disparities exist in similar magnitude across the United States.

In many states, the current Medicare HMO funding system has had the effects of reducing the availability of Medicare HMOs, restricting the types of health care benefits provided, and increasing the cost to enrollees of the benefits that are provided. See Complaint at ¶ 29 (App. C-11). In Minnesota, for example, certain health plan providers have completely withdrawn from or declined to participate in the Medicare HMO risk program. Only three Medicare HMOs remain, which operate almost exclusively in the Minneapolis-St. Paul metropolitan area. Generally, Medicare HMOs are unavailable to senior citizens in rural Minnesota. See Complaint at ¶ 29 (App. C-11).

The defendants argued below that, if senior citizens like Sarno are not satisfied with the benefits available under Medicare+Choice, they simply can switch back to Medicare Part A and Part B. That, however, is not a realistic option. The coverage provided by Parts A and B is limited, and Sarno and others would have to obtain supplemental Medicare insurance. Since Sarno has been a Medicare participant for more than six months, she could not qualify for any reasonably-priced supplemental Medicare insurance without passing a medical screening test. See 42 U.S.C. § 1395ss(s)(2)(A) (requiring that an issuer of Medicare

supplemental policies not deny issuance of a policy because of health status, claims experience, receipt of health care, or medical condition to an individual whose application is submitted within six months after reaching age 65 and who is enrolled for benefits under Medicare Part B.) After six months, these restrictions on issuers of supplemental insurance do not apply. Consequently, coverage may be denied or very high premiums charged.

In their complaint, plaintiffs Minnesota Senior Federation and Sarno assert that the above-described substantial differences in health care benefits provided under the current Medicare HMO funding system deter senior citizens residing in certain states from moving to other states and penalize them if they exercise their right to relocate, requiring that they either stay where they are or move and forgo health care benefits that many cannot afford to purchase on their own. The current Medicare managed care funding system thus imposes a burden upon and penalizes the exercise of senior citizens' constitutional right to travel and relocate from state to state.

REASONS FOR GRANTING THE WRIT

A writ of certiorari should be granted to resolve the conflict between the circuits on whether the same or different standards apply in cases involving the effects of *federal* statutes and in cases involving the effects of *state* statutes on the fundamental right of citizens to travel and relocate from state to state. The writ also should be granted to clarify the source, nature, and scope of the constitutional right to travel and relocate, since prior decisions do not do so, and because of its extraordinary importance in this case involving health care issues affecting millions of the nation's senior citizens and one of our largest national programs. Further, the writ should be granted to correct the decision below and afford

plaintiffs an opportunity to present evidence in support of their allegations that the federal Medicare legislation at issue has an actual deterrent effect on the exercise of their right to travel and relocate from state to state.

A. A Writ of Certiorari Should be Granted to Resolve the Conflict Between the Circuits Regarding Application Against the Federal Government of the Constitutional Right to Travel and Relocate From State to State.

In the present case, the Eighth Circuit Court of Appeals held that the Medicare HMO funding system and its Medicare+Choice reimbursement formula do not implicate the plaintiffs' constitutional right to travel and that the federal statutory scheme is subject only to rational basis review. The Court rejected plaintiffs' argument that a showing that federal legislation has an *actual deterrent effect* on travel and interstate relocation implicates the right and, under the decisions of this Court, makes the legislation subject to careful judicial scrutiny.

The plaintiffs relied on the decision in Attorney General of New York v. Soto-Lopez, 476 U.S. 898, 903 (1986), for the fundamental proposition that a law "implicates the right to travel when it actually deters travel." In affirming the dismissal of plaintiffs' case, the Eighth Circuit distinguished Soto-Lopez on the basis – which it regarded as most important – that Soto-Lopez applied the constitutional right to travel to *state* legislation, not to a *federal* statutory regime. The Court observed that the only Supreme Court decisions concerning the effect of *federal* legislation, such as Aptheker v. Secretary of State, 378 U.S. 500, 503-04 (1964), have dealt with federal restrictions on *international* travel, as opposed to interstate travel. 273 F.3d at 810 and n.3 (App. A–7-8).

The Eighth Circuit found that this Court had "rejected an 'actual deterrence' analysis" in Saenz v. Roe, 526 U.S. 489, 504-05 (1999). 273 F.3d at 810 (App. A–8). Plaintiffs believe that to be an inappropriately narrow reading of Saenz, in which the Supreme Court did not have to look at actual deterrence, because the case concerned a "discriminatory classification [that] is itself a penalty," making the argument that the welfare scheme at issue affected travel only "incidentally" (i.e., the amount of the effect) beside the point. 526 U.S. at 504-05. Saenz cannot fairly be said to "reject" actual deterrence analysis. Nevertheless, the Eighth Circuit concluded that federal social welfare programs such as Medicare are subject only to rational basis review, despite any demonstrated burden or preclusive effect on the travel and relocation of citizens from state to state.

The Eighth Circuit also faulted plaintiffs' claims for not falling within any of the three components of the right to travel described in Saenz. The language of Saenz itself, however – stating that the right "embraces at least three different components" (526 U.S. at 500, emphasis added) – indicates that this Court, in Saenz, was not announcing an exhaustive explication of all possible aspects of the right.[1] Indeed, as the Eighth Circuit acknowledged, the three described components would not cover a case such as Aptheker v. Secretary of State, 378 U.S. 500 (1964), in which the right was held to protect against federal restrictions on international travel. See also Kent v. Dulles, 357 U.S. 116,

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[1] In Saenz, 526 U.S. at 500, the Supreme Court stated that the right –

> embraces at least three different components. It protects the right of a citizen of one State to enter and to leave another State, the right to be treated as a welcome visitor rather than an unfriendly alien when temporarily present in the second State, and, for those travelers who elect to become permanent residents, the right to be treated like other citizens of that State.

129 (1958) (recognizing constitutional right to international travel); Haig v. Agee, 453 U.S. 280, 306-07 (1981) (constitutional right to interstate travel is virtually unqualified, while travel abroad is subject to national security and foreign policy considerations).

Thus, under the decision of the Eighth Circuit in this case, *state* laws are treated as implicating the right to travel and relocate and are subject to the standard of strict scrutiny if they fall within one of the three situations described in Saenz, *federal* laws concerning international travel implicate the right and are subject to strict scrutiny, and *federal* laws concerning social welfare programs such as Medicare do not implicate the right and are subject only to rational basis review, regardless of a demonstrable deterrent effect on interstate travel and relocation.

The opinion of the Eighth Circuit in the present case is directly at odds with the decision of the Seventh Circuit Court of Appeals in Bethesda Lutheran Homes and Servs., Inc. v. Leean, 122 F.3d 443 (7th Cir. 1997). In Bethesda Lutheran, the Seventh Circuit reviewed regulations concerning Medicaid – another federal social welfare program – that made it difficult for certain (indigent incompetent) nonresidents to obtain institutional care in Wisconsin. The federal regulations imposed a monetary penalty on indigents who moved from one state to another, and state requirements made it difficult to become a Wisconsin resident. The Seventh Circuit held that *both* sets of challenged provisions, the *federal* Medicaid regulations and the Wisconsin *state* impediments to residency, violated the constitutional right to travel and relocate from one state to another.

The Seventh Circuit's decision reflects the view that the right to travel and relocate is a single right conferred by the Constitution that is equally applicable against *both* state and

federal action. 122 F.3d at 448-450. The Seventh Circuit determined that, in order to pass constitutional muster, the state requirement had to be justified (122 F.3d at 446) and, likewise, the Medicaid regulations had to be justified (122 F.3d at 448, 449). In support, the Court cited Soto-Lopez, 476 U.S. at 904, 906 and n. 6 (applying scrutiny and requiring compelling justification), and Hooper v. Bernalillo County Assessor, 472 U.S. 612, 618 (1985) (applying scrutiny and requiring the furthering of a legitimate state purpose).

On the facts presented in Bethesda Lutheran, the Seventh Circuit found the constitutional violation to be patent, since one of the states involved refused to pay any benefits at all, creating a gross disparity with obvious implications for interstate movement. 122 F.3d at 449. The Court concluded:

> Both sets of challenged provisions, the state and the federal, violate the right to travel that has been held to be conferred against both state and federal action by the Constitution.

122 F.3d at 450.

Unlike the Eighth Circuit's decision in the present case, determining that a different approach and standards apply to state and federal impediments and deterrents to travel and relocation, the Seventh Circuit's decision in Bethesda Lutheran reflects a common approach to the right, whether the source is state action or federal action. Moreover, the Seventh Circuit's view is consistent with this Court's decision in Shapiro v. Thompson, 394 U.S. 618 (1969), simultaneously invalidating state duration-of-residence requirements and a similar federal requirement that Congress had imposed on the District of Columbia. 394 U.S. at 641-42. It is also consistent with the principle that the federal government cannot make a classification which, if made by a state, would

offend the Constitution. See Bolling v. Sharpe, 347 U.S. 497, 499 (1954). Indeed, in Saenz v. Roe, on which the Eighth Circuit heavily relied in the present case, this Court invalidated both a state statute and a federal statute purportedly authorizing the same result.[2] 526 U.S. at 507.

Here, a writ of certiorari should be granted to resolve these divergent views of the Courts of Appeals on the fundamental issue of whether the constitutional right to travel and relocate is a right equally applicable against *state* statutes and statutory regimes and *federal* statutes and statutory regimes, making them subject to the same standards of scrutiny and justification. The Seventh Circuit has determined that it is, and the Eighth Circuit disagrees, holding below that *federal* statutes and statutory regimes are to be treated differently than *state* ones, with impediments and deterrent effects on international travel treated as implicating the right, but with federal impediments and deterrent effects on interstate travel and relocation created by federal social welfare legislation regarded as not implicating the right, leaving such legislation subject only to more deferential, rational basis review. This conflict on the basic analysis and standards to be applied, which portends further discrepant rulings in the lower courts, should be addressed and resolved.

[2] As a practical matter, to those adversely affected, it makes no difference whether the source of their burden or dilemma is state legislation or federal legislation.

B. A Writ of Certiorari Should be Granted to Clarify the Source, Scope, and Analysis to be Applied in Cases Involving the Right to Travel and Relocate, Because of the Importance of the Issue, Which is Here Presented in a Case Concerning the Health Care of Millions of the Nation's Senior Citizens and one of our Largest National Programs.

Although the word "travel" is not found in the text of the Constitution, the "constitutional right to travel from one State to another" is firmly embedded in American jurisprudence. Saenz v. Roe, 526 U.S. 489, 498 (1999) (quoting United States v. Guest, 383 U.S. 745, 757 (1966)). The right to travel has been described as "a virtually unconditional personal right, guaranteed by the Constitution," assertable against private interference as well as governmental action. Shapiro v. Thompson, 394 U.S. 618, 643 (1969) (Stewart, J. concurring). The "nature of our Federal Union and our constitutional concepts of personal liberty unite to require that all citizens be free to travel throughout the length and breadth of our land uninhibited by statutes, rules or regulations which unreasonably burden or restrict this movement." Saenz, 526 U.S. at 499 (quoting Shapiro, 394 U.S. at 629); see also Kent v. Dulles, 357 U.S. 116, 126 (1958) (citing Z. Chafee, Three Human Rights in the Constitution of 1787, 171-181, 187 et seq. (1956)).

While the Supreme Court has recognized the right in a variety of circumstances and discussed several constitutional provisions that support its application, the Court has not always found it necessary to identify its precise constitutional basis. See Saenz, 526 U.S. at 501 (acknowledging lack of identification of source and grounding at least one component of the right in the Privileges and Immunities Clause of the Fourteenth Amendment); Guest, 383 U.S. at 758 (describing

the right to travel as originating in the Articles of Confederation and as being a "necessary concomitant of the stronger Union the Constitution created."); Edwards v. California, 314 U.S. 160, 173-74 (1941) (describing the right as being grounded in the Commerce Clause); Zobel v. Williams, 457 U.S. 55, 60, n. 6 (1982) (noting that the nature and source of the right to travel remain obscure and analyzing cases under the Equal Protection Clause of the Fourteenth Amendment); Shapiro, 394 U.S. at 630-31 (describing the right as deriving from general principles of federalism); and Hooper v. Bernalillo County Assessor, 472 U.S. 612, 618 (1985) (analyzing right to travel claim under the Equal Protection Clause of the Fourteenth Amendment).

In Soto-Lopez, the Court summarized the right as follows:

> Freedom to travel throughout the United States has long been recognized as a basic right under the Constitution. And it is clear that the freedom to travel includes the freedom to enter and abide in any State in the Union.
>
> The textual source of the constitutional right to travel, or, more precisely, the right of free interstate migration, has proved elusive. . . . Whatever its origin, the right to migrate is firmly established and has been repeatedly recognized in our cases.

476 U.S. at 901-03 (plurality opinion) (citations and internal quotations omitted). In the same passage, the Court referred to the lack of need to locate this right definitively in any particular constitutional provision, in part because of the "unquestioned historic acceptance of the principle of free interstate migration." 476 U.S. at 902.

Without clear definition of the source and nature of the right, however, the analysis of cases and circumstances will continue to be characterized by perplexity and unpredictability. In Zobel, a member of the Court suggested that the Court's task should be "to articulate this constitutional principle, explaining its textual sources," thus avoiding the establishment of "an uncertain jurisprudence." 457 U.S. at 72-73 (O'Connor, J. concurring). Twenty years later, however, the uncertainty persists.

This case presents an appropriate occasion and context for clarification of the source of the right to travel, its nature and boundaries, and the analysis and standards to be applied in the cases in which it is asserted. The subject matter could hardly be more important. Medical care is a basic necessity. See Memorial Hosp. v. Maricopa County, 415 U.S. 250, 258-59, 261 (1974) (finding that medical care is "a basic necessity of life" and requiring justification for denial of non-emergency medical care to persons who migrated interstate). Moreover, the scope of this case is broad, since the claims here at issue concern the availability of medical and health care benefits to senior citizens under a major national program in which nearly forty million Americans are participants.[3]

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[3] The issues in this case are of particular concern to many persons who – absent a Medicare HMO – may be unable to obtain full health care coverage. After turning age 65, an individual has six months in which to obtain supplemental insurance without having to submit to underwriting procedures. See 42 U.S.C. § 1395ss(s)(2)(A). To obtain supplemental insurance after the six-month period has expired, an individual over 65 must pass a health screening process. Many elderly persons, particularly those who choose a Medicare HMO because of their poor health, cannot pass the screening and thus either cannot obtain supplemental insurance or can do so only at a very high cost. For such persons, a Medicare HMO is the only realistic means of obtaining prescription drugs and other necessary medical care.

In the decision below, the Court of Appeals noted that most of this Court's "modern cases" on the right to travel concern *state* legislation. 273 F.3d at 810 and n.3 (App. A–7-8). The existence and nature of the right, of course, do not depend upon the number or recentness of the decided cases. This Court has clearly held that the right applies, not only to *state*, but to *federal* legislation. See, e.g., Kent v. Dulles, 357 U.S. 116 (1958); Aptheker v. Secretary of State, 378 U.S. 500 (1964); Haig v. Agee, 453 U.S. 280 (1981); Shapiro, 394 U.S. at 641. The scope of the right and the analysis to be employed in cases in which it is asserted, however, have not been fully developed. Here, fundamental questions include whether the analysis to be undertaken is the same with respect to the effects of federal legislation on interstate travel and relocation as it is with respect to state legislation, and the nature of the *comparison* to be made.

In this case, the plaintiffs allege that senior citizens are deterred from traveling and relocating from state to state – and are penalized if they do so – by the Medicare HMO funding system. The case concerns the impact and effects of federal laws and regulations (whose scope of application is *nationwide*), as opposed to the impact and effects of state laws and regulations (whose scope of application is *statewide*). The question here is *not* the one that has surfaced most frequently in right to travel cases: whether a particular state law treats new residents differently than existing residents, and if so, whether the difference is justifiable. In cases concerning the impact of a *state* law, the internal comparison, such as those made in Shapiro and Saenz, is natural and appropriate; the situation of the newcomer is compared with that of the long-time state resident.

When the inquiry concerns the impact and effects of a *national* system on interstate travel and relocation, however, the relevant comparison is not the situation of a newcomer in

the destination state and that of a long-time resident of that state. Such comparisons turn a blind eye to the nationwide applicability of federal legislation. For *national* legislation, the relevant comparison is the national one: the person's situation under the legislation before the desired interstate move (plaintiff Sarno in Florida) and the person's situation under the legislation after the desired interstate move (plaintiff Sarno in Minnesota). Yet, the internal *state* comparison was the one made by both the District Court and the Court of Appeals in this case. The District Court found that new residents of Minnesota would have the same right to government benefits as enjoyed by other residents (102 F. Supp.2d at 1127; App. B-24), while the Eighth Circuit noted the "citizen's right to be treated equally in her new State of residence" (273 F.3d at 810, quoting from Saenz) and that "Sarno would be treated equally with other Minnesotans if she moved there." 273 F.3d at 810 (App. A-9). That misses the real point, which is the effect of the state-to-state move on her medical care and benefits under the same national program created by the same federal legislation.

A writ of certiorari should be granted to determine the proper analysis to be employed and comparisons to be made in cases involving the effects of nationally-applicable *federal* legislation, as distinguished from *state* legislation, and to clarify the scope and nature of the right of citizens to travel and move from state to state. Review pursuant to certiorari is particularly appropriate in view of the importance of this case in which the rights at issue concern the medical and health care benefits provided to millions of the nation's senior citizens.

C. The Decision of the Court of Appeals Should be Reversed to Afford Plaintiffs an Opportunity to Present Evidence in Support of Their Allegations That the Medicare+Choice Reimbursement Formula Actually Deters Travel and Relocation From State to State.

In Attorney General of New York v. Soto-Lopez, 476 U.S. 898 (1986), the Supreme Court reviewed a number of decisions and indicated that the right to travel is implicated when a law actually deters travel, when impeding travel is its primary objective, or when it uses any classification that serves to penalize the exercise of that right. The Court specifically recognized that the right can be burdened in an "indirect manner" by laws that result in the unequal distribution of rights and benefits. 476 U.S. at 903.

The opinion of the Court in Soto-Lopez implicitly requires that a plaintiff requesting that a particular law be subjected to careful scrutiny show something more than a negligible or minimal impact on the right to travel. See Soto-Lopez, 476 U.S. at 921 (O'Connor, J. dissenting). Thus, plaintiffs asserting right-to-travel claims are required, as a threshold matter, to show that the burden on travel or interstate movement caused by the law in question is more than minimal. See, e.g., Miller v. Reed, 176 F.3d 1202, 1205 (9th Cir. 1999) (finding the effect of gasoline taxes and toll roads too minor to violate the right to travel); Kansas v. United States, 16 F.3d 436, 442 (D.C. Cir. 1994) (finding that the impact of a restriction on air travel to and from the Dallas-Fort Worth area was negligible or trivial and thus did not violate the right to travel); Cramer v. Skinner, 931 F.2d 1020, 1031 (5th Cir. 1991) (finding no constitutional right to the most convenient form of travel).

The plaintiffs in the present case acknowledge that they must satisfy the threshold requirement. They have specifically alleged a substantial burden on their right to travel and relocate interstate, and they seek an opportunity to present evidence in support of their allegations. In their complaint, plaintiffs allege that Mary Sarno is a beneficiary of Medicare, a national health care program created by federal statutes and implemented nationwide by federal regulations. She faces a financial burden and would incur a penalty of thousands of dollars in the form of lost medical benefits and additional health care costs if, as she wishes, she moves from Florida to Minnesota to live with her daughter. Among other things, she would have to pay an annual premium of more than $1100 to a Minnesota Medicare HMO and monthly prescription drug costs of approximately $800, expenses fully covered by her Florida Medicare HMO. Her constitutional right to travel and relocate is subjected to this burden and potential penalty as a result of the geographic funding disparities created by the Medicare+Choice reimbursement formula for Medicare HMOs. She thus alleges that the current HMO funding system deters her from moving and directly impairs her right to travel and relocate. See Complaint at ¶¶ 9, 56 (App. C–4-5, 17).

Plaintiff Sarno should be afforded an opportunity to present evidence in support of her allegations and to demonstrate that the challenged federal law and regulations – the HMO funding system of Medicare+Choice – impose a substantial burden on her right to travel and relocate to another state, and that the geographic disparities in the availability of Medicare benefits thus created actually deter interstate movement and relocation. This factual inquiry should not have been decided on a motion to dismiss under Fed. R. Civ. P. 12(b)(6).

The decision of the Court of Appeals affirming dismissal of the complaint for failure to state a claim should be reversed, and the plaintiffs should be afforded an opportunity to present evidence in support of their allegations.

CONCLUSION

For the foregoing reasons, this petition for a writ of certiorari should be granted.

Respectfully submitted,

Dated:
March 13, 2002

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United States Court of Appeals
FOR THE EIGHTH CIRCUIT

No. 00-3139

Minnesota Senior Federation, Metropolitan Region; Mary Sarno,	*	
Plaintiffs-Appellants,	*	
v.	*	Appeal from the United States District Court for the District of Minnesota.
United States of America; Tommy G. Thompson,* Secretary of Health and Human Services.	*	
Defendants-Appellees,	*	

Submitted: May 17, 2001

Filed: December 13, 2001

Before LOKEN, ROSS, and FAGG, Circuit Judges.

LOKEN, Circuit Judge.

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* Tommy G. Thompson has been appointed to serve as Secretary of Health and Human Services, and is substituted as appellee under Federal Rule of Appellate Procedure 43(c)(2).

The "Medicare+Choice" program was enacted as part of the Balanced Budget Act of 1997 and is now codified at 42 U.S.C. §§ 1395w-21 to w-28. The program includes reimbursement provisions that encourage managed health care organizations to be cost-effective and to pass cost savings on to their members in the form of additional benefits or reduced charges. As under prior law, cost effectiveness is measured by a formula based primarily on "fee-for-service" health care costs in each local community, an approach that results in substantial geographic variations. Though Congress intended to reduce these disparities, the Medicare+Choice formula still produces wide variations in the payments Medicare provides to managed health care providers. Because "excess" payments may be passed on to Medicare beneficiaries, the end result is that Medicare benefits are more generous in some communities than in others.

In this case, the Minnesota Senior Federation and Mary Sarno, a Florida resident who would like to live with her daughter in Minnesota, seek a declaratory judgment that the Medicare+Choice formula violates their constitutional rights to travel and to equal protection of the law. The district court[1] granted defendants' motion to dismiss for failure to state a claim upon which relief may be granted. Minnesota v. United States, 102 F. Supp. 2d 1115 (D. Minn. 2000).[2] The Federation and Sarno appeal. Reviewing the dismissal de novo, and taking all facts alleged in the complaint as true, see Knapp v. Hanson, 183 F.3d 786, 788 (8th Cir. 1999) (standard of review), we affirm.

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[1] The HONORABLE DONALD D. ALSOP, United States District Judge for the District of Minnesota.

[2] The district court also dismissed the State of Minnesota's claim that the Medicare+Choice formula violates its rights under the Tenth Amendment. See 102 F. Supp. 2d at 1119-23. The State did not appeal that ruling.

I. Background

Medicare was established in 1965 and presently serves some thirty-nine million elderly and disabled Americans. Uniform benefits were initially provided under Medicare Part A and Medicare Part B, and these programs continue today. See 42 U.S.C. §§ 1395c-1395i-5; 1395j-1395w-4. For beneficiaries who enroll in Parts A and B and elect to obtain benefits on a "fee-for-service" basis, Medicare payments are made for each service rendered. Amounts Medicare pays to providers vary in part because of geographic differences in the fees charged for providing those services.

In 1972, Congress enacted Medicare Part C, a program that permits managed health care organizations to enter into "risk contracts" under which the organization provides a full range of Medicare services and receives a single monthly capitation payment for each enrollee. See 42 U.S.C. § 1395mm; 42 C.F.R. § 417.594. Capitation payments are determined by a formula that is based upon the projected cost of treating beneficiaries under the traditional fee-for-service system. Thus, the formula incorporates wide geographic variations in health care costs. But under Medicare Part C, the variations can result in different benefits to Medicare beneficiaries because, when a managed care organization receives more in capitation payments from Medicare than it costs to provide Medicare services to its enrollees (an "excess" that is determined by a complex formula), it may pass this cost saving on to enrollees in the form of reduced premiums, reduced co-payments, or additional health care benefits. See 42 U.S.C. § 1395mm(g)(2); 42 C.F.R. § 417.592.

Medicare+Choice, which is the new Medicare Part C, was enacted in 1997 to "allow beneficiaries to have access to a wide array of private health plan choices in addition to traditional fee-for-service Medicare....[and] enable the

Medicare program to utilize innovations that have helped the private market contain costs and expand heath care delivery options." H.R. Conf. Rep. No. 105-217, at 585 (1997), reprinted in 1997 U.S.C.C.A.N. 176, 205-06. Medicare+ Choice includes a modified capitation payment formula intended to reduce the prior geographic payment variations. But the government concedes that substantial discrepancies remain. For example, Mary Sarno is a Medicare Part C enrollee who lives in Broward County, Florida. In 1999, the managed care reimbursement rate for Broward County, Florida, was $676.64. Sarno's daughter lives in Minnesota. In 1999, the managed care reimbursement rate, for Dakota County, Minnesota, was $394.92. The generous reimbursement rate in Broward County enabled Sarno's plan to offer unlimited prescription drugs, no co-payments for physician visits and various services, and no annual premium. By contrast, Medicare Part C enrollees in Dakota County paid an annual premium of $1,137, were charged higher co-payments, and received virtually no prescription drug coverage. Such disparities are the basis for appellants' claims that the Medicare+Choice formula violates their travel and equal protection rights.

II. Discussion

The Federation and Sarno attack the discriminatory impact of the Medicare+Choice formula because it results, for example, in Medicare beneficiaries in southern Florida receiving more benefits at less cost than their similarly situated counterparts in Minnesota. Appellants mount two constitutional challenges to this federal statutory regime. First, they argue that because the formula implicates the constitutional right to travel, it is subject to strict scrutiny and fails that standard of review because it is not narrowly tailored to meet a compelling government interest. Second, they argue in the alternative that the formula does not

withstand even deferential rational basis review and therefore violates their right to equal protection guaranteed by the Due Process Clause of the Fifth Amendment.

A. Equal Protection. We agree with the district court that appellants' alternative equal protection argument is without merit. When a federal economic or social welfare program is challenged on equal protection grounds, and no suspect class or fundamental constitutional right is implicated, the proper standard of judicial review is rational basis, the "paradigm of judicial restraint." FCC v. Beach Communications, Inc., 508 U.S. 307, 314 (1993). Congress does not violate the right to equal protection "merely because the classifications made by its laws are imperfect," Dandridge v. Williams, 397 U.S. 471, 485 (1970), "or because in practice [a classification] results in some inequality," Lindsley v. Natural Carbonic Gas Co., 220 U.S. 61, 78 (1911). "In areas of social and economic policy, a statutory classification...must be upheld against equal protection challenge if there is any reasonably conceivable state of facts that could provide a rational basis for the classification." Beach Communications, 508 U.S. at 313.

Distributing Social Security and Medicare benefits is a massive undertaking which "requires Congress to make many distinctions among classes of beneficiaries while making allocations from a finite fund." Bowen v. Owens, 476 U.S. 340, 345 (1986). Accordingly, the Supreme Court has rejected numerous equal protection challenges to the ways in which these benefits are distributed. Congress adopted the Medicare+Choice program as a means of containing costs and expanding health care delivery options. These are legitimate objectives. Appellants argue that the Medicare+Choice formula is irrational because it discriminates against Medicare beneficiaries enrolled with efficient providers, like those in Minnesota. We reject this argument for the reasons stated by the district court:

> [T]his decision -- to allow managed care organizations to share "savings" with Medicare beneficiaries instead of requiring them to return the difference to the Medicare program itself -- hardly renders the Medicare+Choice program unconstitutional on equal protection grounds.... The Medicare+Choice program increases the health care options of a number of elderly Americans while reducing the strain on the public fisc. The fact that not all elderly Americans...enjoy the same windfall as others is unfortunate, but not unconstitutional. Perhaps there are better solutions or solutions that are more fair, but the Medicare+Choice payment method is certainly "rational" in a constitutional sense.

102 F. Supp. 2d at 1125. It was not irrational or arbitrary for Congress to devise a payment formula based on local health care costs and then to encourage cost-efficient managed care providers to increase benefits for their Medicare enrollees. Though the resulting geographic benefit discrepancies may seem unfair, "equal protection is not a license for courts to judge the wisdom, fairness, or logic of legislative choices." Beach Communications, 508 U.S. at 313.

B. The Right to Travel. No doubt fearing that the Medicare+Choice formula would survive rational basis review, appellants primarily contend that it must be subjected to, and cannot survive, strict scrutiny because it impinges upon the constitutional right to travel. The district court concluded that the formula does not implicate the constitutional right to travel. 102 F. Supp 2d at 1126-28. We agree.

Although the word travel is not found in the Constitution, the Supreme Court has frequently recognized "the

constitutional right to travel from one State to another." Saenz v. Roe, 526 U.S. 489, 498 (1999) (quotation omitted). Because travel is a fundamental right, "any classification which serves to penalize the exercise of that right, unless shown to be necessary to promote a *compelling* governmental interest, is unconstitutional." Shapiro v. Thompson, 394 U.S. 618, 634 (1969). In Saenz, 526 U.S. at 500, the Court recently reviewed its many right-to-travel cases and concluded that this right:

> embraces at least three different components. It protects the right of a citizen of one State to enter and to leave another State, the right to be treated as a welcome visitor rather than an unfriendly alien when temporarily present in the second State, and, for those travelers who elect to become permanent residents, the right to be treated like other citizens of that State.

Appellants' right-to-travel claims do not fall within the three components identified in Saenz. Rather, in arguing that the Medicare+Choice formula must be subjected to the strict scrutiny applied in right-to-travel cases, appellants rely primarily on dicta from the plurality opinion in an earlier case stating that "[a] state law implicates the right to travel when it actually deters such travel . . . ." Attorney General of New York v. Soto-Lopez, 476 U.S. 898, 903 (1986) (plurality opinion). The constitutional right to travel is implicated in this case, appellants argue, because Mary Sarno and others are deterred from moving to a community they would prefer by the reduced Medicare benefits they would receive from a managed care provider in that other community. We reject this right-to-travel theory for several reasons.

First, and most importantly, Soto-Lopez -- and the Court's other modern cases -- have applied the federal constitutional right to travel to *state* legislation that had a

negative impact on travel between the various States.[3] Here, on the other hand, appellants attack a *federal* statutory regime because it allegedly deters interstate travel. In effect, appellants argue that a federal program that fails to achieve nationwide uniformity in the distribution of government benefits is subject to strict scrutiny because it will deter travel to unfavored locales. Such a contention is clearly too broad.[4] Not surprisingly, it finds no support in the Supreme Court's right-to-travel cases. Instead, the Court has-emphasized time and again that rational basis review is appropriate in considering the constitutionality of federal social welfare programs such as Medicare. See Bowen v. Gilliard, 483 U.S. 587, 601-03 (1987) (rejecting the argument that an AFDC amendment should be subjected to "heightened scrutiny" because it "interferes with a family's fundamental right to live in the type of family unit it chooses").

Second, appellants cite no later case applying the "deterrent" dicta of Soto-Lopez. Earlier cases such as Shapiro and Memorial Hospital v. Maricopa County, 415 U.S. 250, 257 (1974), spoke of state restrictions that "served to *penalize* the exercise of the right to travel." In Saenz, the Court summarized its right-to-travel jurisprudence without citing Soto-Lopez, and it rejected an "actual deterrence" analysis, focusing instead on "the citizen's right to be treated equally in her new State of residence." 526 U.S. at 504-05.

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[3] Except for cases dealing with federal restrictions on international travel, such as Aptheker v. Secretary of State, 378 U.S. 500, 503-04 (1964), the Court's right-to-travel jurisprudence has focused on a fundamental issue of federalism, the extent to which States may restrict American citizens' right to travel within their nation. See, e.g., the concurring opinions of Justice Brennan and Justice O'Connor in Zobel v. Williams, 457 U.S. 55, 65, 71 (1982).

[4] Appellants' theory would seemingly call into question an entire host of federal programs, including Medicaid, Temporary Assistance to Needy Families, and numerous agricultural subsidies, all of which provide different benefit levels based on regional price conditions.

Here, Sarno would be treated equally with other Minnesotans if she moved there; she is deterred from moving because she would be voluntarily giving up more generous benefits available in Florida. In these circumstances, the Medicare+ Choice formula is not affirmatively *penalizing* her right to travel. We conclude the Supreme Court would not extend the constitutional right to travel to governmental disincentives of this type, provided of course that they withstand rational basis review.

For these reasons, and those lucidly stated by the district court, see 102 F. Supp. 2d at 1126-28, we conclude that the right to travel is not implicated by the Medicare+Choice formula and therefore is subject only to rational basis review. As the current formula satisfies this deferential standard, the judgment of the district court must be affirmed. However unfairly the current Medicare Part C funding mechanism may seem to impact some classes of Medicare beneficiaries, "the fact the line might have been drawn differently at some points is a matter for legislative, rather than judicial, consideration." United States R.R. Ret. Bd. v. Fritz, 449 U.S. 166, 179 (1980).

A true copy.

Attest:

CLERK, U. S. COURT OF APPEALS,
EIGHTH CIRCUIT.

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

STATE OF MINNESOTA, by its Attorney General, Mike Hatch; MINNESOTA SENIOR FEDERATION – METROPOLITAN REGION; and MARY SARNO,

Plaintiffs,

v.

THE UNITED STATES OF AMERICA and DONNA E. SHALALA, Secretary of Health and Human Services,

Defendants.

No. 99 Civ. 1831 DDA/FLN

ORDER

DAVID WOODWARD, Assistant Attorney General of the State of Minnesota, St. Paul, Minnesota, appeared on behalf of Plaintiff the State of Minnesota.

DANIEL E. GUSTAFSON, Heins Mills & Olsen, P.L.C., Minneapolis, Minnesota, appeared on behalf of Plaintiffs Minnesota Senior Federation - Metropolitan Region and Mary Sarno.

MICHELLE B. GOODMAN, United States Department of Justice, Civil Division, Washington, D.C., appeared on behalf of Defendants.

The question presented in this case is whether the Medicare managed care payment formula set forth in the Balanced Budget Act ("BBA") of 1997, Pub. L. No.105-33, violates the Constitution. The Court holds that it does not and therefore will grant Defendants' motion to dismiss.

I.

A.

Congress established Medicare in 1965 as part of the Social Security Act, 42 U.S.C. § 1395 et seq., to provide federally-funded medical insurance for the elderly and disabled. It is a massive program, in fiscal year 1997 approximately 38.8 million people were enrolled, Fischer v. United States, —U.S.—,120 S.Ct. 1780, 1783, —L.Ed.2d— (2000), making it the largest health insurance program in the United States.

Health care benefits covered under the Medicare program are divided into two parts, Part A and Part B. Medicare Part A covers hospital insurance, including inpatient hospital care, skilled nursing facility care, home health agency care, and hospice care. See 42 U.S.C. §§ 1395c-1395i-5. Part A is financed through a federal income tax on self-employment income (the Self-Employment Contributions Act) and federal employment taxes on wages paid to employees (primarily under the Federal Insurance Contributions Act, or FICA). Medicare Part B provides supplemental medical insurance for such things as physician services, laboratory and diagnostic tests, durable medical equipment, medical supplies, ambulance services, and prescription drugs that cannot be self-administered. See id. §§ 1395j-1395w-4. Part B is voluntary and requires payment of a monthly premium which is uniform throughout the country.

Persons enrolling under Parts A and B historically have had two basic coverage options. They can elect to obtain

services through a fee-for-service system under which program payments are made for each service rendered. Or, they can participate in a managed care organization, like a health maintenance organization ("HMO"), which has entered into a payment agreement with Medicare. This suit challenges the method for reimbursing managed care organizations under the BBA, specifically the "Medicare+ Choice" program.

B.

Prior to the passage of the BBA, the payment methods for managed care organizations were set forth in section 1876 of the Social Security Act, 42 U.S.C. § 1395mm, under what was then Part C of the Medicare program. Section 1876 permitted managed care organizations to enter into either a cost contract or a risk contract, depending on certain statutory requirements. See 42 U.S.C. § 1395mm(a), (g), (h); see also 42 C.F.R. §§ 417.530-.576 (cost contract); id. §§ 417.580-.598 (risk contract). Basically, under a section 1876 cost contract, Medicare paid the actual cost the organization incurred in furnishing covered services. Under a section 1876 risk contract, Medicare paid the organization a single monthly capitation payment in advance for each of its enrollees, and, in return, the organization agreed to provide the full range of Medicare services through an organized system of affiliated physicians, hospitals, and other providers. See generally H. Conf. Rep. No. 105-217, at 582-83 (1997), reprinted in 1997 U.S.C.C.A.N. 176, 203-04.

Under section 1876 risk contracts, the monthly capitation payment paid to managed care organizations was based on the adjusted average per capita cost ("AAPCC"). 42 U.S.C. § 1395mm(a)(4); see 42 C.F.R. § 417.584. The AAPCC was Medicare's estimate of the average per capita amount it would cost to treat a given beneficiary under the fee-for-service system. This amount took into consideration the

beneficiary's county of residence and certain other demographic characteristics, such as age, sex, and disability status. 42 U.S.C. § 1395mm(a)(4); see 42 C.F.R. § 417.588(c). For each Medicare beneficiary enrolled in a managed care organization, Medicare paid the organization 95% of the AAPCC rate corresponding to the demographic class to which each beneficiary was assigned. 42 U.S.C. § 1395mm(a)(1)(C); see 42 C.F.R. § 417.584(b)(1).

By nature of being a risk contract, if the actual costs associated with an enrollee were higher than the AAPCC rate, the managed care organization was at risk for the amount. If the costs were lower, the organization could keep the amount of the difference or return it to the Medicare program. Specifically, section 1876 provided that HMOs or other qualified organizations were required at the beginning of each year to determine their adjusted community rate ("ACR"). The ACR was essentially a calculation of the insurance premium the plan would charge a commercial customer for providing Medicare-covered services to the enrollee. 42 U.S.C. § 1395mm(e)(3); see 42 C.F.R. § 417.594. An HMO with an ACR that was less than the AAPCC had the option of passing the "savings" on to its enrollees in the form of reduced co-payments or additional health benefits not covered by Medicare, such as prescription drugs, eyeglasses and hearing aids. 42 U.S.C. § 1395mm(g)(2)-(3); see 42 C.F.R. § 417.592(b)(1), (c). Or, the HMO could elect to have its monthly payments reduced or contribute all or a portion of the excess into a stabilization fund. 42 U.S.C. § 1395mm(g)(2); see 42 C.F.R § 417.592(b)(2)-(4). As alleged in the Complaint, most plans opted to pass the savings on to their enrollees in order to attract additional enrollees and increase profitability, name recognition, and market share.

C.

In the BBA of 1997, Congress added sections 1851 through 1859 to the Social Security Act, 42 U.S.C. §§ 1395w-21-1395w-28, to establish a new Part C of the Medicare program, known as the "Medicare+Choice" program.[1] The stated purpose of Medicare+Choice was to "allow beneficiaries to have access to a wide array of private health plan choices in addition to traditional fee-for-service Medicare...[and to] enable the Medicare program to utilize innovations that have helped the private market contain costs and expand health care delivery options." H. Conf. Rep. No. 105-217, at 585 (1997), reprinted in 1997 U.S.C.C.A.N. 176, 205-06. In particular, Medicare+Choice was designed to increase the options for eligible individuals beyond a traditional managed care plan available under section 1876, such as an HMO, by providing three types of plans: "M+C coordinated care plans (including plans offered by health maintenance organizations, preferred provider organizations, and provider-sponsored organizations), M+C 'MSA' plans, that is, a combination of a high deductible M+C health insurance plan and a contribution to an M+C medical savings account (MSA), and M+C medical private fee-for-service plans." 63 Fed. Reg. 34968, 34968 (1998).

In addition, Congress under the Medicare+Choice program sought to improve the method by which it calculates payment rates to risk contracting plans. See 42 U.S.C. § 1395w-23; see also 42 C.F.R. §§ 422.249-.268. As the Health Care Financing Administration recognized, "[t]he AAPCC had been legitimately criticized for its wide range of payment rates among geographic regions–in some cases it varied by over 20 percent between adjacent counties." 63 Fed. Reg. at 35004. Now, under Medicare+Choice, capitation rates are the

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[1] The existing Part C of the statute, which included section 1876, was redesignated as Part D. 63 Fed. Reg. 34968, 34968 (1998).

greater of: (1) a "blended" capitation rate, taking into account both the local, area-specific Medicare costs on which the old AAPCC rates were based and the national costs,[2] (2) a minimum monthly payment, which in 1998 was $367, or (3) a minimum percentage increase of 2% over the previous year's capitation rate. 42 U.S.C. § 1395w-23(c)(1); see 42 C.F.R. § 422.252. Thus, while it did not abandon the old AAPCC rates entirely, Medicare+Choice attempted to narrow the amount of payment variation across the country through the use of a new reimbursement formula.

Geographic funding disparities nonetheless persist under the Medicare+Choice payment method. According to the Complaint:

> • [I]n 1997 the reimbursement level for HMOs serving Hennepin County, Minnesota residents was $405.63 per member per month, while the reimbursement level for HMOs serving residents in Richmond County, New York, was $767.35 per member per month, a difference of $361.72. Under the BBA, both counties received a 2% increase for 1998. This increased the reimbursement rate in Hennepin County to $413.74...and increased the Richmond County, New York, reimbursement rate to $782.70. The result was to widen the gap between these illustrative counties to a $368.96 difference.

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[2] The blended rate is adjusted further by a budget neutrality factor designed to ensure that the aggregate payment equals the amount that would have been paid under the AAPCC rate alone. 42 U.S.C. § 1395w-23(c)(5); see 42 C.F.R. § 422.254(d). The blended rate is to be phased in over a six year period, from 1998 through 2002. 42 U.S.C. § 1395w-23(c)(2); see 42 C.F.R. § 422.254(a). For the years 1998 and 1999, the budget neutrality adjustment reduced the blended rate to the point where no county's payment rate was based upon the blended rate, since one of the two other rates was higher in every county. 63 Fed. Reg. at 35005.

- [I]n 1999, the Medicare managed care monthly reimbursement rate for Dakota County, Minnesota, is $394.92. By comparison, the 1999 reimbursement rate for Broward County, Florida, is $676.64; for Los Angeles County, California, $647.70; and for Dade County, Florida, $778.45.

Complaint ¶ 27.

Under Medicare+Choice, moreover, like under section 1876 risk contracts, managed care organizations receiving more from Medicare than it costs them to provide coverage may pass on these savings to their enrollees. 42 U.S.C. § 1395w-24(f)(1); see 42 C.F.R. § 422.312. As under the old system, Medicare+Choice relies on participating plans to provide their ACR. It further requires them, when the ACR is less than what they receive, either to provide additional benefits with the excess or to return the amount to the Medicare program. Id. The Complaint alleges that this results in a substantial difference in the cost, type, and variety of medical services available to Medicare beneficiaries in different parts of the country:

> A senior citizen participating in a Medicare managed care health plan in Broward County[, Florida] pays no annual premium, pays no co-payment for visiting her doctor and pays nothing for prescription drug coverage, for a covered ambulance trip, for outpatient mental health treatments, or for emergency medical services. By contrast, a Minnesota senior citizen enrolled in a Medicare managed care plan in Dakota County pays an annual premium of $1,137, incurs a $10 co-payment for each doctor visit, must pay out-of-pocket for almost

> all prescription drugs, must pay twenty percent of the costs of out-of-area ambulance services, pays a $15-$30 co-payment for each mental health session, pays a $30 co-payment for emergency services and must pay a $30 co-payment for urgently needed services.

Complaint ¶ 2.

D.

This action was brought by the State of Minnesota, by its attorney general (the "State), and the Minnesota Senior Federation and Mary Sarno (the "private plaintiffs") against the United States and Donna Shalala, the Secretary of Health and Human Services, alleging that the Medicare+Choice payment formulation is unconstitutional.[3] The State alleges that the Medicare+Choice program violates its state sovereignty and principles of federalism guaranteed by the Constitution, including the Tenth Amendment. It contends that, as a result of the funding disparities under the Medicare managed care program, it has incurred significant increased costs in meeting the healthcare needs of its senior citizens. In particular, it claims that the State legislature has had to respond to the funding disparities by enacting a legislative program subsidizing the prescription drug costs of eligible, low income senior citizens in Minnesota. See Minn. Stat. § 256.955.

The private plaintiffs allege that the Medicare+Choice payment method violates their equal protection rights because

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[3] A number of amici curiae also have filed briefs, including members of the Minnesota Congressional Delegation; the States of Kansas, Maine, New Mexico, Oregon, Utah and Vermont, by their respective Attorneys General; the Minnesota Medical Association, Hennepin Medical Society, Ramsey Medical Society, and American Medical Association; the Care Providers of Minnesota; and the National Rural Health Association. All of the amici curiae support Plaintiffs' Complaint.

it is not rationally related to a legitimate government end. They argue that, contrary to the stated legislative purpose, the Medicare+Choice payment formula has restricted the availability and scope of health benefits and increased the cost of benefits for senior citizens in Minnesota. The private plaintiffs also allege that the Medicare+Choice program violates their fundamental right to travel. In particular, Mary Sarno, a Florida resident, alleges that she is deterred from and would be penalized for moving to Minnesota because of the geographic funding disparities for managed care organizations.

The State and the private plaintiffs seek a judgment declaring the Medicare managed care funding scheme unconstitutional and an order enjoining the current method of payment. Defendants have moved to dismiss the Complaint under Federal Rule of Civil Procedure 12(b)(6).

II.

A motion to dismiss under Rule 12(b)(6) should be granted where "'it appears beyond doubt that the plaintiff can prove no set of facts which would entitle him to relief.'" Knapp v. Hanson, 183 F.3d 786, 788 (8th Cir. 1999) (citation omitted). In ruling on a Rule 12(b)(6) motion, the Court takes all facts alleged in the complaint as true and construes the allegations in the complaint and all reasonable inferences arising from the complaint in the light most favorable to the plaintiff. Id. In response to Defendants' motion to dismiss, the State and the private plaintiffs submitted voluminous affidavits and exhibits. At oral argument, however, all parties agreed that the motion could be decided based solely on the facts alleged in the Complaint. Accordingly, the Court turns to those allegations.

III.

Under the First Claim for Relief, the State alleges that, in adopting and implementing the Medicare+Choice funding scheme, Defendants have infringed upon the State's sovereign interest in a manner that violates principles of federalism inherent in our structure of dual government. The State purports to find support for its allegation in a number of constitutional doctrines limiting the power of the federal government, "including but not limited to the Tenth Amendment." (Complaint ¶¶ 49-51.) Defendants counter that Congress' decisions on how to fund and operate Medicare, an exclusively federal program, are authorized under its Spending Clause power and do not interfere with the powers reserved to the states by the Tenth Amendment. They contend further that none of the other federalism concerns cited by the State call the constitutionality of the Medicare+Choice payment formulation into question.

A.

The Court will begin with the State's claim that Medicare+Choice violates the Tenth Amendment. It is of course true that "our Constitution establishes a system of dual sovereignty between the States and the Federal Government." Gregory v. Ashcroft, 501 U.S. 452, 457, 111 S.Ct. 2395, 2399, 115 L.Ed.2d 410 (1991). Under our system, the federal government possesses only those powers enumerated in the Constitution. Id. "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to people," by the Tenth Amendment. U.S. Const. amend. X.

The State does not challenge Defendants' position that the Medicare program–at least as a whole–is a proper exercise of Congress' power under the Spending Clause to "provide for the...general Welfare of the United States." U.S. Const.

art. l, § 8, cl. 1. Nor does it appear that it could. See Children's Healthcare Is a Legal Duty, Inc. v. Vladeck, 938 F. Supp. 1466, 1483 (D. Minn. 1996) ("There can be little question that the Medicare and Medicaid Acts are programs of disbursement of funds pursuant to Congress' taxing and spending power[.]"); see also Helvering v. Davis, 301 U.S. 619, 640-45, 57 S.Ct. 904, 908-10, 81 L.Ed. 1307 (1937) (determining that Congress' decision to fund certain portions of the Social Security Act–of which Medicare is a part–is a proper use of its spending power). Instead, the State appears to contend that the Tenth Amendment limits the power of Congress to spend in the way it has chosen. Relying on New York v. United States, 505 U.S. 144, 112 S.Ct. 2408, 120 L.Ed.2d 120 (1992) and Printz v. United States, 521 U.S. 898, 117 S.Ct. 2365, 138 L.Ed.2d 914 (1997), the State argues that Congress, by enacting the Medicare+Choice funding scheme, has "indirectly but essentially directed" State legislative policy and "commandeered" the State's legislative process by effectively requiring the State to pass legislation and appropriate funds to meet the unmet health care needs of seniors. (Complaint ¶ 49.)

The State's reliance on the anticommandeering principle of New York and Printz is plainly misplaced. In New York, the Court considered the constitutionality of three provisions of the Low-Level Radioactive Waste Policy Amendments Act of 1985, a statute requiring state participation in the disposal of nuclear waste. The Court held that the first two provisions were supported by affirmative grants of power to Congress, and therefore "not inconsistent with the Tenth Amendment." Id. at 173, 174, 112 S.Ct. at 2427. The third provision, the "take title" provision, required states either to enact legislation providing for the disposal of radioactive waste generated within their borders, or to take title to and possession of the waste. The Court held that both of these options crossed the line from encouragement of a state to regulate in a particular way to outright "coercion." Id. at 175,

112 S.Ct. at 2428. "Either way, 'the Act commandeers the legislative processes of the States by directly compelling them to enact and enforce a federal regulatory program,' an outcome that has never been understood to lie within the authority conferred upon Congress by the Constitution." Id. at 176, 112 S.Ct. at 2428 (quoting Hodel v. Virginia Surface Mining & Reclamation Ass'n, Inc., 452 U.S. 264, 288, 101 S.Ct. 2352, 2366, 69 L.Ed.2d 1 (1981)). In Printz, the Court extended New York's ban on commandeering the state legislative process to prohibit "conscripting" state executive officials to enforce a federal regulatory program. Printz, 521 U.S. at 935, 117 S.Ct. at 2384. At issue in Printz were certain interim provisions of the Brady Handgun Violence Prevention Act of 1993 that required local police departments to conduct a background check on individuals who wanted to purchase a handgun. Two law enforcement officers objected to the provisions, arguing that they were "being pressed into federal service" and contending that congressional action "compelling state officers to execute federal laws is unconstitutional." Id. at 905, 117 S.Ct. at 2369-70. A majority of the Court agreed. Citing New York, it held that the federal government "may neither issue directives requiring the States to address particular problems, nor command the States' officers, or those of their political subdivisions, to administer or enforce a federal regulatory program." Id. at 935, 117 S.Ct. at 2384.

The difference between New York and Printz and this case is stark. In those cases, Congress unambiguously required the states to enact or enforce a federal regulatory program. Here, in contrast, Congress has not required the State or its officers to do anything. The State legislature may have felt pressure to enact legislation to meet the unmet health care needs of its seniors, but this pressure would have come from its own citizens, not Congress. Moreover, any claim that Congress "indirectly" compelled the members of the State legislature to act is not of constitutional significance.

The holdings of New York and Printz are clear: the Tenth Amendment's anticommandeering principle prohibits only direct federal compulsion. See New York, 505 U.S. at 161, 112 S.Ct. at 2420 (Congress may not "'commandee[r] the legislative process of the States by directly compelling them to enact and enforce a federal regulatory program'") (emphasis added) (quoting Hodel); Printz, 521 U.S. at 933, 117 S.Ct. at 2383 ("The mandatory obligation imposed on [law enforcement officers] to perform background checks on prospective handgun purchasers plainly runs afoul of [this] rule.") (emphasis added).

For similar reasons, the State's suggestion that the Medicare+Choice payment formulation violates its state sovereignty because it, and not Congress, will be held politically accountable for the high costs of health care within its borders lacks merit. To be sure, the Supreme Court in its Tenth Amendment decisions has expressed concern that "where the Federal Government directs the States to regulate, it may be state officials who will bear the brunt of public disapproval, while the federal officials who devised the regulatory program may remain insulated from the electoral ramifications of their decisions." New York, 505 U.S. at 169, 112 S.Ct. at 2424; see also Printz, 521 U.S. at 529-30, 117 S.Ct. at 2382. But Medicare is a federal program administered by the federal government. Claims that citizens will hold the State accountable for Medicare's shortcomings are therefore particularly specious. As noted above, this case does not raise the concerns addressed in New York and Printz: the federal government has not "conscripted" state officials into enforcing the Medicare program, nor has it "commandeered" the State into the service of the federal government. The political accountability rationale for striking down federal laws as an infringement on state sovereignty thus is not implicated.

In short, the Medicare+Choice payment formulation "does not require the [Minnesota] legislature to enact any

laws or regulations, and it does not require state officials to assist in the enforcement of federal statutes regulating private individuals." Reno v. Condon, —U.S.—, 120 S.Ct. 666, 672, 145 LEd.2d 587 (2000). The Court therefore rejects the State's claim that the Medicare+Choice payment formulation violates the Tenth Amendment and the principles announced in New York and Printz.

B.

The State also relies on a number of additional doctrines limiting the power of the federal government to argue that the Medicare+Choice program is unconstitutional. Other than highlighting the concerns over various types of intrusions into the sovereignty of the states, however, these doctrines are largely irrelevant here. Indeed, none of them call the constitutionality of the Medicare+Choice program into question.

The State, for example, mistakenly relies on (a different) New York v. United States, 326 U.S. 572, 66 S.Ct. 310, 90 L.Ed. 326 (1946), for what it calls a "nondiscrimination rule." At issue in New York was the doctrine of intergovernmental tax immunity and, specifically, whether the federal government could tax New York State's mineral water business. The Court sustained the tax. Id. at 581, 66 S.Ct. at 314. In doing so, the Court indicated that a discriminatory tax, falling only on the states and not on private parties, would be an unconstitutional interference with the functioning of state government. Id. at 575-76, 66 S.Ct. at 311. Thus, the so-called nondiscrimination rule of New York prohibits Congress from taxing the states as states. It has no applicability in this litigation, where there is no contention that Congress has singled out the states for different treatment than private individuals. The State's claim that New York stands for a much broader prohibition against legislation generating funding inequalities is without support.

Similarly misguided are the State's citations to the Supreme Court's recent Eleventh Amendment jurisprudence. The Eleventh Amendment and cases interpreting it generally prohibit citizens from suing a state without its consent. See Kimel v. Florida Bd. of Regents, —U.S.—, 120 S.Ct. 631, 145 L.Ed.2d 522 (2000); Alden v. Maine, 527 U.S. 706, 119 S.Ct. 2240, 144 L.Ed.2d 636 (1999); Seminole Tribe of Florida v. Florida, 517 U.S. 44, 116 S.Ct. 1114, 134 L.Ed.2d 252 (1996). But the Medicare+Choice payment formula does not implicate the State's sovereign immunity, so citations to this body of law are curiously out of place.

The State's contentions regarding the lack of a general federal police power and the State's interest in protecting public health also are unavailing. Even the State admits, as it must, that the federal government can legislate in areas of traditional state concern, including public health. See Medtronic, Inc. v. Lohr, 518 U.S. 470, 475, 116 S.Ct. 2240, 2246, 135 L.Ed.2d 700 (1996) (noting how "in recent decades the Federal Government has played an increasingly significant role in the protection of the health of our people"). The State, nonetheless, relies on United States v. Lopez, 514 U.S. 549, 115 S.Ct. 1624, 131 L.Ed.2d 626 (1995), to argue that Congress has legislated "in an unconstitutional manner, in a way that infringes upon a state's sovereign interests." (State's Mem. in Opp'n to Defs.' Mot. to Dismiss at 21.) The comparison between Lopez and this case is without merit, however. In Lopez, the Court held that Congress overstepped its bounds under the Commerce Clause to make it a crime to possess a gun in a school zone. Lopez, 514 U.S. at 551, 115 S.Ct. at 1626.[4] In contrast, Congress' authority under the

[4] For a more recent case reaching a similar result, see United States v. Morrison, —U.S.—, 120 S.Ct. 1740, 1754, —L.Ed.2d— (2000) (holding that Congress lacked authority under the Commerce Clause and § 5 of the Fourteenth Amendment to provide a civil remedy for victims of gender-motivated violence).

Spending Clause to choose how to fund the Medicare program is not in doubt.

Finally, the several states appearing as amici curiae erroneously suggest that the Medicare+Choice payment formula offends the so-called "equality principle" from Coyle v. Smith, 221 U.S. 559, 31 S.Ct. 688, 55 L.Ed. 853 (1911). The Supreme Court has said that the equality principle is a narrow doctrine: it "applies only to the terms upon which States are admitted to the Union." South Carolina v. Katzenbach, 383 U.S. 301, 328-29, 86 S.Ct. 803, 819, 15 L.Ed.2d 769 (1966). Thus, in Coyle, the Court held that Congress could not tell Oklahoma, as a condition to its admission to the Union, where to locate its capital because that would place it on a "plane of inequality with its sister states." Coyle, 221 U.S. at 565, 31 S.Ct. at 689. Amici curiae's attempt to expand this doctrine to fit the facts of this case borders on the frivolous.

At best, then, the above limitations on the power of the federal government serve as an unremarkable reminder that "we are a nation composed of States," New York, 326 U.S. at 575-76, 66 S.Ct. at 311, and that our Constitution "specifically recognizes the States as sovereign entities." Seminole Tribe, 517 U.S. at 71 n.15, 116 S.Ct. at 1131 n.15. But they do nothing to aid the State in this case.

IV.

In the Second Claim for Relief, the private plaintiffs allege that the Medicare+Choice funding method violates their equal protection rights under the Due Process Clause of the Fifth Amendment.[5] Their basic contention is that the

[5] The Supreme Court has held that where the federal government makes a classification which, if made by a state, would violate the Equal Protection Clause of the Fourteenth Amendment, then the classification violates the Due Process Clause of the Fifth Amendment. Bolling v.

Medicare+Choice payment formulation treats senior citizens differently based solely on where they live without a rational basis for doing so. Defendants respond that the Medicare+ Choice program furthers Congress' legitimate end of expanding health care options while containing Medicare costs in a way that is consistent with our equal protection guarantees.

In areas of economic and social welfare, it is well-understood that the government does not violate equal protection "merely because the classifications made by its laws are imperfect." Dandridge v. Williams, 397 U.S. 471, 485, 90 S.Ct. 1153, 1161, 6 L.Ed.2d 393 (1970). "The general rule is that legislation is presumed to be valid and will be sustained if the classification drawn by the statute is rationally related to a legitimate [government] interest." City of Cleburne v. Cleburne Living Center, 473 U.S. 432, 440, 105 S.Ct. 3249, 3254, 87 L.Ed.2d 313 (1985). This standard of review has been called the "paradigm of judicial restraint." FCC v. Beach Communications, Inc., 508 U.S. 307, 314, 113 S.Ct. 2096, 2101, 124 L.Ed.2d 211 (1993). A law will not be struck down "simply because the classification 'is not made with mathematical nicety or because in practice it results in some inequality.'" Dandridge, 397 U.S. at 485, 90 S.Ct. at 1161 (quoting Lindsley v. Natural Carbonic Gas Co., 220 U.S. 61, 78, 31 S.Ct. 337, 340, 55 L.Ed. 369 (1911)).

Citing the legislative history, as noted above, Defendants explain that the purpose of the Medicare+Choice program was to contain costs and expand health care delivery options. These two goals undoubtedly are legitimate, and amici curiae's suggestion that Congress' objective was something much narrower is disingenuous.[6] The real question, therefore,

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Sharpe, 347 U.S. 497, 499-500, 74 S.Ct. 693, 694-95. 98 L.Ed. 884 (1954).

[6] For example, members of the Minnesota Congressional Delegation assert that the purpose behind Medicare+Choice was "to furnish participating plans with uniform incentives to provide non-covered

is whether the means chosen to achieve these ends is rational. On this, the Court has little difficulty in concluding that it is.

This is not the first case to raise an equal protection challenge to a legislative decision on how to distribute funds under the Social Security Act. In other cases involving similar claims, the Supreme Court has regularly upheld the legislature's decision under rational basis review. See, e.g., Bowen v. Gilliard, 483 U.S. 587, 600, 107 S.Ct. 3008, 3017, 97 L.Ed.2d 485 (1987) (rejecting equal protection challenge to provision in the AFDC statute that required families wishing to receive benefits to take into account child support payments made by a noncustodial parent because it was "rational for Congress to adjust the AFDC program to reflect the fact that support money generally provides significant benefits for the entire family unit"); Bowen v. Owens, 476 U.S. 340, 350, 106 S.Ct. 1881, 1887, 1887, 90 L.Ed.2d 316 (1986) (holding that certain provisions of the Social Security Act that denied widow's benefits to divorced widows who remarried did not violate equal protection because it was rational for Congress to conclude that "divorced widowed spouses did not enter into marriage with the same level of dependency on the wage earner's account as widows or widowers"); Dandridge, 397 U.S. at 486, 90 S.Ct. at 1162 (holding that Maryland's decision to limit the funds available under AFDC to $250 per month was rationally related to its "legitimate interest in encouraging employment and in avoiding discrimination between welfare families and the families of the working poor"). Much of this can be

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benefits." (Mem. of Amici Curiae Minn. Cong. Delegation at 6.) This attempt to narrow Congress' objective is not just belied by the record, but also the law is well-established that "those attacking the rationality of the legislative classification have the burden 'to negative every conceivable basis which might support it.'" Beach Communications, 508 U.S. at 315, 113 S.Ct. at 2102 (emphasis added) (quoting Lehnhausen v. Lake Shore Auto Parts Co., 410 U.S. 356, 364, 93 S.Ct. 1001, 1006, 35 L.Ed.2d 351(1973)).

attributed to the deference courts must pay to Congress in these matters:

> "Governmental decisions to spend money to improve the general public welfare in one way and not another are 'not confided to the courts. The discretion belongs to Congress, unless the choice is clearly wrong, a display of arbitrary power, and not an exercise of judgment.'" Mathews v. De Castro, 429 U.S. 181, 185, 181, 185, 97 S.Ct. 431, 434, 50 L.Ed.2d 389 (1976) (quoting Helvering v. Davis, 301 U.S. 619, 640, 57 S.Ct. 904, 908, 81 L.Ed.2d 1307 (1937)).

Owens, 476 U.S. at 345, 106 S.Ct. at 1885. Indeed, as the Supreme Court has recognized, "Congress faces an unusually difficult task in providing for the distribution of benefits under the [Social Security] Act. The program is a massive one, and requires Congress to make many distinctions among classes of beneficiaries while making allocations from a finite fund." Id.

In light of these concerns, this Court concludes that Medicare+Choice is rationally related to Congress' legitimate objective of containing costs and expanding health care delivery options. The Medicare+Choice program increases the health care delivery options because it allows many (but certainly not all) elderly Americans to choose between a fee-for-service program, a traditional managed care plan, such as a HMO, or a broad range of plans comparable to those now available through private insurance. It also seeks to contain costs by ensuring that Medicare will not be paying more to managed care organizations than it has to pay in the same county under the traditional fee-for-service program.

The Medicare+Choice payment formulation, moreover, seeks to improve on the previous section 1876 risk contract method of payment. Now, rather than relying solely on the

AAPCC rate, Medicare+Choice provides for capitation rates that are the greater of three amounts. The Medicare+Choice payment method is not perfect–it still results in payment rates that vary geographically, and sometimes the amount does not precisely reflect a managed care organization's actual costs. But this discrepancy is the result of geographical differences in the historical fee-for-services costs, and any suggestion that Congress acted irrationally in relying on these historical numbers is untenable in light of the principles underlying rational basis review. See Beach Communications, 508 U.S. at 313, 113 S.Ct. at 2101 ("[E]qual protection is not a license for courts to judge the wisdom, fairness, or logic of legislative choices."); see also Dandridge, 397 U.S. at 485, 90 S.Ct. at 1161 (acknowledging that "'[t]he problems of government are practical ones and may justify, if they do not require, rough accommodations–illogical, it may be, and unscientific'") (quoting Metropolis Theatre Co. v. City of Chicago, 228 U.S. 61, 69-70, 33 S.Ct. 441, 443, 57 L.Ed. 730 (1913)).

This brings us to the private plaintiffs' main objection to the Medicare+Choice payment method. They object that under the Medicare+Choice program, as under the section 1876 risk contracts, managed care organizations receiving more money from Medicare than it costs them to provide services to their enrollees are able to apply the excess either to reduce deductibles and co-payments or to offer additional benefits and services not covered by Medicare. This, the private plaintiffs argue, rewards traditionally high cost and inefficient providers at the expense of more efficient providers, like in Minnesota. But this decision–to allow managed care organizations to share "savings" with Medicare beneficiaries instead of requiring them to return the difference to the Medicare program itself–hardly renders the Medicare+Choice program unconstitutional on equal protection grounds. "[I]n the administration of a fund that is large enough to have a significant impact on the Nation's deficit, general rules must be examined in light of the broad

purposes they are intended to serve." Gilliard, 483 U.S. at 598-99, 107 S.Ct. at 3016. The Medicare+Choice program increases the health care options of a number of elderly Americans while reducing the strain on the public fisc. The fact that not all elderly Americans–including those in Minnesota–do not enjoy the same windfall as others is unfortunate, but not unconstitutional. Perhaps there are better solutions or solutions that are more fair, but the Medicare+ Choice payment method is certainly "rational" in a constitutional sense.

V.

In the Third Claim for Relief, the private plaintiffs allege that the Medicare+Choice program violates their fundamental right to travel.[7] In particular, Mary Sarno alleges that she is deterred from from moving from Florida to Minnesota because of the geographic funding disparities for managed care organizations participating in Medicare+Choice. Defendants counter that the Medicare+Choice payment formulation, which applies nationwide, does not implicate the right to travel. They argue that, unlike state residency requirements, the effect of the application of the payment formulation is to treat residents of the same county equally, whether they be new or old.

The right to travel has been firmly established and repeatedly recognized. See e.g., Saenz v. Roe, 526 U.S. 489, 119 S.Ct. 1518, 143 L.Ed.2d 689 (1999); Shapiro v.

[7] The Supreme Court has referred to right to travel analysis as "little more than a particular application of equal protection analysis." Zobel v. Williams, 457 U.S. 55, 60 n.6, 102 S.Ct. 2309, 2312 n.6, 72 L.Ed.2d 672 (1982). However, because the right to travel is a fundamental right, any law burdening the right is subject to the strict scrutiny standard of review. See Shapiro v. Thompson, 394 U.S. 618, 634, 89 S.Ct. 1322, 1331, 22 L.Ed.2d 600 (1969). The result under the Third Claim for Relief therefore potentially could be different than under the Second Claim for Relief.

Thompson, 394 U.S. 618, 89 S.Ct. 1322, 22 L.Ed.2d 600 (1969); Edwards v. California, 314 U.S. 160, 62 S.Ct. 164, 86 L.Ed. 119 (1941); Crandall v. State of Nevada, 73 U.S. (6 Wall.) 35 (1867). This is true even though the word "travel" is not found in the Constitution. The Supreme Court has offered various sources for the right, including the Commerce Clause, the Privileges and Immunities Clause of Article IV, and the Privileges and Immunities Clause of the Fourteenth Amendment. See Attorney General of New York v. Soto-Lopez, 476 U.S. 898, 902, 106 S.Ct. 2317, 2320, 90 L.Ed.2d 899 (1986). Regardless of its source, however, "freedom to travel throughout the United States has long been recognized as a basic right under the Constitution." United States v. Guest, 383 U.S. 745, 758, 86 S.Ct. 1170, 1178, 16 L.Ed.2d 239 (1966).

The Supreme Court in Saenz recently collected and clarified the case law governing the right to travel. According to the Court, the right to travel "embraces at least three different components":

> It protects the right of a citizen of one State to enter and to leave another State, the right to be treated as a welcome visitor rather than an unfriendly alien when temporarily present in the second State, and, for those travelers who elect to become permanent residents, the right to be treated like other citizens of that State.

526 U.S. at __, 119 S.Ct. at 1525.[8] By far, the majority of recent Supreme Court cases have addressed the third

[8] The Supreme Court prior to Saenz defined the right to travel this way: "A state law implicates the right to travel when it actually deters such travel, when impeding travel is its primary objective, or when it uses any classification which serves to penalize the exercise of that right." Soto-Lopez, 476 U.S. at 903, 106 S.Ct. at 2321 (internal quotations and citations omitted). In their brief, the private plaintiffs primarily rely on

component–that is, "the right of the newly arrived citizen to the same privileges and immunities enjoyed by other citizens of the same State." Id. at __, 119 S.Ct. at 1526. In these cases, the Court has considered state laws that, by classifying residents according to the time they established residence, resulted in the unequal distribution of rights and benefits among otherwise qualified bona fide residents.

Statutes imposing these durational residency requirements are often struck down, most recently in Saenz. There, the Court held unconstitutional a California statute limiting the maximum welfare benefits available to newly arrived residents to the amount payable by the State of the family's prior residence. Id. at __, 119 S.Ct. at 1527-30. Likewise, in Shapiro the Court concluded that statutory provisions which completely denied welfare assistance to residents of a State or the District of Columbia who had not resided within their jurisdictions for at least one year immediately preceding their applications for assistance was unconstitutional. Shapiro, 394 U.S. at 627-38, 89 S.Ct. at 1328-33. Other durational residency requirements have suffered a similar fate. See, e.g., Soto Lopez, 476 U.S. 898, 106 S.Ct. 2317, 90 L.Ed.2d 899 (1986); Memorial Hospital v. Maricopa County, 415 U.S. 250, 94 S.Ct. 1076, 39 L.Ed.2d 306 (1974); Dunn v. Blumstein, 405 U.S. 330, 92 S.Ct. 995, 31 L.Ed.2d 274 (1972).

The Medicare+Choice program plainly does not implicate the same concerns as these durational residency

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this earlier formulation to argue that Medicare+Choice violates their right to travel. While there is no suggestion that the Court's formulation in Soto-Lopez is inconsistent with the description in Saenz, this Court concludes that since Saenz is the most recent statement governing the right to travel, "it provides the proper framework for conducting the required analysis" of Medicare+Choice. See United States v. Morrison, __ U.S. at __, 120 S.Ct. at 1749 (2000) (concluding that it should analyze Commerce Clause issue under the framework set forth its most recent decision).

requirement cases, despite the private plaintiffs' reliance on many of them. As one court explained in a case raising a right to travel challenge to the payment methodology to calculate Medicare payments to home health agencies, "The challenged statute is not a state law separating one state from others, as in Shapiro v. Thompson..., but a Congressional act enforced nationwide. This law implements the same reimbursement system in all states." Vermont Assembly of Home Health Agencies, Inc. v. Shalala, 18 F. Supp. 2d 355, 363 (D. Vt. 1998). Under Medicare+Choice, Congress has not placed any conditions on the amount of time a person spends in a state before she is entitled to benefits. New residents have "the same right to vital government benefits and privileges in the States to which they migrate as are enjoyed by other residents." Memorial Hospital, 415 U.S. at 261, 94 S.Ct. at 1084. Thus, the Court finds that the third component of the right to travel is not implicated.

Medicare+Choice also does not violate the other two components of the right to travel. The second component does not apply because the private plaintiffs do not seek to be treated as "welcome visitors." Rather, they seek to become permanent residents of Minnesota. The first component is equally inapplicable. The first component involves the "right to go from one place to another, including the right to cross state borders while en route." Saenz, 526 U.S. at __, 119 S.Ct. at 1525. Laws which place an "obstacle" or an "actual barrier" to a person's right to free interstate movement interfere with this aspect of the right. See id. at __, 119 S.Ct. at 1525 (explaining that law which does not impose an "obstacle" does not offend this component); Zobel, 457 U.S. at 60 n.6, 102 S.Ct. at 2312 n.6 (stating that right to travel protects persons against the erection of "actual barriers" to interstate movement); cf. Soto-Lopez, 476 U.S. at 903, 106 S.Ct. at 2321 (stating that law implicates the right to travel when it "actually deters" such travel). Thus, in Edwards v. California, the Court struck down a statute that prohibited the

transportation of indigent persons across the California border as a state interference with interstate commerce. 314 U.S. at 174, 62 S.Ct. at 167. Similarly, in United States v. Guest, the Court held that the district court erred in dismissing an indictment brought under the criminal sections of the Civil Rights Act of 1964 against six whites for depriving black citizens of the right to travel freely to and from Georgia. 383 U.S. at 759-60, 86 S.Ct. at 1178-79. The concerns of Edwards and Guest are not at issue here, however, because Medicare+Choice, like the statute in Saenz, does not impose an actual obstacle to the right to enter and leave a state. Saenz, 526 U.S. at __, 119 S.Ct. at 1525.

The private plaintiffs' final fall back position is that the Supreme Court's three-pronged characterization of the right to travel in Saenz was not meant to be a limitation on that right. (See Minnesota Senior Federation and Mary Sarno's Mem. in Opp'n to Defs.' Mot. to Dismiss at 29 (emphasizing Court's language that right to travel embraces "at least three" different components).) Even if true, which this Court does not decide, the cases on which the private plaintiffs rely for their expansive reading of the right to travel do not help them.[9] For example, the private plaintiffs cite decisions recognizing a right to intrastate travel and a right to international travel.[10] The private plaintiffs also rely on a decision striking down a statute imposing a tax on residents leaving a state and on nonresidents merely passing through,[11] and on a decision upholding a statute making willful

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[9] The Court expresses no opinion as to whether any of the cases the private plaintiffs' cite could be categorized under one of the three components in Saenz.

[10] E.g., Apetheker v. Secretary of State, 378 U.S. 500, 84 S.Ct. 1659, 12 L.Ed.2d 992 (1964) (international travel); Kent v. Dulles, 357 U.S. 116, 78 S.Ct. 1113, 2 L.Ed.2d 1204 (1958) (international travel); Lutz v. City of New York, 899 F.2d 255 (3rd Cir. 1990) (intrastate travel).

[11] Crandall v. State of Nevada, 73 U.S. (6 Wall.) 35 (1867).

abandonment of a child by a parent a misdemeanor if the parent remained in the state and a felony if the parent left the state.[12] Medicare+Choice, however, does not raise any of the problems addressed in these cases, and thus the Court declines to expand the right to travel to fit this case based on a few citations to inapposite precedents.

VI.

Plaintiffs have brought to the Court's attention the glaring disparities in the amount of Medicare reimbursement paid to managed care organizations throughout the country. These differences in payments create significant differences in the cost, type, and variety of medical services available to Medicare recipients nationwide. "But the Constitution does not empower this Court to second-guess [legislative] officials charged with the difficult responsibility of allocating limited public welfare funds among the myriad of potential recipients." Dandridge, 397 U.S. at 487, 90 S.Ct. at 1163. This Court's role is only to determine if the laws, as written, violate the Constitution. The reimbursement formula set forth in the Medicare+Choice program does not.

The Court's conclusion that Medicare+Choice does not violate the Constitution is not to be considered a judicial endorsement of a reimbursement system which even Defendants concede results in gross unequal treatment of senior citizens. It is to be hoped that those with ultimate authority to remedy this wrong–indeed those who created it–will promptly recognize the injustice they have created and enact legislation to correct it.

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[12] Jones v. Helms, 452 U.S. 412, 101 S.Ct. 2434,69 L.Ed.2d 118 (1981).

* * *

Upon its review of the files, motions and proceedings herein, it is hereby ORDERED that:

1. The motion to dismiss brought by Defendants United States of America and Donna E. Shalala, Secretary of Health and Human Services, is GRANTED, and the claims against them are DISMISSED;

2. The clerk of the court shall enter judgment as follows:

> **It is hereby ORDERED, ADJUDGED and DECREED that Plaintiffs' claims against all Defendants are dismissed in their entirety.**

DATED: July 6, 2000

s/
DONALD D. ALSOP, Senior Judge
United States District Court

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

State of Minnesota, by its Attorney General, Mike Hatch; Minnesota Senior Federation - Metropolitan Region; and Mary Sarno,

Plaintiffs,

v.

The United States of America and Donna E. Shalala, Secretary of Health and Human Services,

Defendants.

Court File No.: 99-CV-1831 DDA/FLN

COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

For their complaint against defendants United States of America and Donna E. Shalala, Secretary of Health and Human Services, plaintiffs State of Minnesota, by its Attorney General Mike Hatch, the Minnesota Senior Federation - Metropolitan Region, and Mary Sarno allege as follows. The allegations and other factual contentions have evidentiary support or are likely to have evidentiary support after a reasonable opportunity for further investigation or discovery.

I. NATURE OF THE CASE

1. Medicare, the nation's largest health insurance program serving approximately 39 million elderly and disabled Americans, was enacted in 1965 as a uniform, nondiscriminatory nationwide program based on equality in funding and equality in the provision of a standardized

package of health benefits to beneficiaries regardless of where they reside. Beginning in 1972 and continuing to the present, Congress enacted and the Department of Health and Human Services implemented, amendments to the Social Security Act designed to provide Medicare to beneficiaries through managed care organizations. These amendments have used a reimbursement formula that has transformed a nondiscriminatory, uniform national program into one in which the availability, cost, and scope of additional health benefits available to senior citizens participating in a Medicare managed care health plan vary substantially depending upon the county and state in which the beneficiary resides. These significant disparities continue to exist despite the fact that all beneficiaries contribute in equal percentages to the funding of Medicare.

2. For example, the Medicare managed care reimbursement formula provides for a reimbursement rate in 1999 of $676.64 in Broward County, Florida, but a rate of only $394.42 for Dakota County, Minnesota. A senior citizen participating in a Medicare managed care health plan in Broward County pays no annual premium, pays no co-payment for visiting her doctor and pays nothing for prescription drug coverage, for a covered ambulance trip, for outpatient mental health treatments, or for emergency medical services. By contrast, a Minnesota senior citizen enrolled in a Medicare managed care plan in Dakota County pays an annual premium of $1,137, incurs a $10 co-payment for each doctor visit, must pay out-of-pocket for almost all prescription drugs, must pay twenty percent of the costs of out-of-area ambulance services, pays a $15-$30 co-payment for each mental health session, pays a $30 co-payment for emergency services and must pay a $30 co-payment for urgently needed services.

3. This scheme of unequal distribution of Medicare funding which results in inequalities in health care benefits violates the State of Minnesota's rights as a separate

sovereign under the system of federalism created and secured by the United States Constitution, violates the rights of senior citizen Medicare beneficiaries to equal protection and denies their right to travel as guaranteed by the United States Constitution. Plaintiffs State of Minnesota, the Senior Federation of Minnesota - Metropolitan Region and Mary Sarno seek a judgment declaring this Medicare managed care funding scheme unconstitutional and an Order enjoining the current pattern of inequitable payments under the Medicare managed care program, specifically including such unequal payments made under the Medicare Part C ("Medicare+ Choice") program enacted in 1997.

II. JURISDICTION AND VENUE

4. Jurisdiction in this Court is proper pursuant to 5 U.S.C. § 702, 28 U.S.C. §§ 1331 and 1346. Plaintiffs seek relief pursuant to 28 U.S.C. § § 2201, 2202, and Rule 57 of the Federal Rules of Civil Procedure. Because plaintiffs challenge the constitutional validity of the method of reimbursement of certain Medicare managed care provisions of the Social Security Act; exhaustion of administrative remedies is not required. The Minnesota Senior Federation - Metropolitan Region has presented its complaints to the Secretary of Health and Human Services. In any event, plaintiffs' constitutional claims are collateral to any particular claim for benefits and are not susceptible to review in the administrative appeals process.

5. Plaintiff State of Minnesota's claims for injunctive and declaratory relief are based on the State's rights as a separate sovereign under the system of federalism secured by the United States Constitution, including without limitation by the Tenth Amendment. The claims for injunctive and declaratory relief of plaintiffs Senior Federation of Minnesota - Metropolitan Region, and Mary Sarno are derived from the Equal Protection component of the Due Process Clause of the

Fifth Amendment and the right to travel secured by the United States Constitution.

6. Venue is proper under 28 U.S.C. §1391(e), because plaintiff Minnesota Senior Federation - Metropolitan Region resides in this district, no real property is involved in this action and a substantial part of the events or omissions giving rise to the claims occurred in this district.

III. PARTIES

7. Mike Hatch, the duly elected Attorney General of the State of Minnesota, brings this action pursuant to his common law and statutory authority, including Minn. Stat. § 8.01 (1998), on behalf of the State of Minnesota in its capacity as a sovereign state.

8. Plaintiff Minnesota Senior Federation - Metropolitan Region ("MSF") is an advocacy organization for seniors located at 1885 University Avenue West, Saint Paul, Minnesota. The MSF seeks to assist older Minnesotans by promoting values of dignity, unity, quality and satisfaction of life. Pursuant to its mission and purposes, for many years the MSF has itself, and working through a coalition of other interested persons and organizations, sought to address the geographic funding disparities under the Medicare managed care program through efforts including legislative advocacy, education and, now, legal action. The MSF includes in its membership persons who are beneficiaries under the Medicare program, including Medicare Part C. The MSF's members have standing to sue and the interests that the MSF seeks to protect through this action are germane to its purpose. The relief that the MSF seeks does not demand participation of its individual members in this lawsuit.

9. Plaintiff Mary Sarno, a Medicare Part C enrollee, is 72 years old and currently resides in Florida. Because her daughter lives in Minnesota, Ms. Sarno wants to move to Minnesota, but she cannot because the Medicare Part C health

coverage in Minnesota is insufficient to meet her healthcare expenses and needs and is far less comprehensive than her Medicare Part C health coverage currently provided under her Medicare managed care plan in Florida. For example, Ms. Sarno and her spouse require over $800 of monthly prescription medicines which are covered by her Florida HMO but would not be covered in Minnesota. Furthermore, it is unlikely that Ms. Sarno would be eligible for any supplemental Medicare insurance. On repeated occasions, Ms. Sarno has made inquiries to the MSF and insurance representatives about the costs of prescription drugs, Medicare and supplemental insurance that she would incur if she moved to Minnesota. Ms. Sarno has also made inquiries to the MSF and to local realtors regarding housing costs.

10. Defendant the United States of America, by action of Congress, passed the Medicare statutes as amendments to the Social Security Act that give rise to this action.

11. Defendant the Secretary of the United States Department of Health and Human Services, Donna E. Shalala, is responsible for the implementation and administration of the Medicare managed care program, including the Medicare Part C program enacted in 1997.

IV. FACTUAL BACKGROUND

12. Medicare, established in 1965, is a nationwide health insurance program for elderly and certain disabled people. It is the nation's largest health insurance program. Medicare Part A, which pays primarily for institutional health care costs, such as hospital services, is funded from the Medicare Trust Fund out of uniform payroll taxes on employers, employees and the self-employed. Medicare Part B, which primarily covers physician services, laboratory services, durable medical equipment, outpatient hospital services and other non-institutional medical services, is funded from general tax revenues and through monthly premiums assessed

against participating beneficiaries. These premiums are uniform throughout the country. Every permanent resident of the United States who is over 65 years old and worked, or whose spouse worked, for at least 10 years is eligible for Medicare.

13. Congress provided for a uniform, designated package of health benefits and services to be included in Medicare Part A. 42 U.S.C. § 1395d. Congress further provided for a uniform, designated package of health benefits or services to be included in Medicare Part B. 42 U.S.C. § 1395j. In both Part A and Part B, Medicare pays for benefits in the form of fees for each medical service ("fee-for-service").

14. At and since the inception of the Medicare program, taxpaying individuals across the nation have paid into the Medicare program by a formula based on uniform percentages of earnings. The formula applies to all taxpayers and equally in all areas of the United States.

15. In 1972, Congress amended the Social Security Act in an effort to incorporate managed care principles and to bring health maintenance organizations ("HMOs") into the Medicare program. Congress added Section 1876 to Title 18 of the Social Security Act, which authorized a new method of payment to HMOs. It provided for capitation payments for Parts A and B services on either a cost or risk basis and established the principle that HMOs choosing risk contracts would receive some of the savings resulting from efficiencies.

16. More specifically, in 1972, Congress adopted and implemented a capitation payment methodology or formula for paying participating managed care organizations a monthly capitation payment to provide the Medicare set of benefits to each enrollee. The capitation payment methodology is a county-based formula that compares the actual cost an HMO spent on healthcare per member with an actuarial calculation of the average adjusted per capita cost ("AAPCC"). The AAPCC represents an actuarial projection

of what it would cost to treat a particular category of Medicare beneficiary under traditional fee-for-service Medicare. Congress authorized payments to an HMO on a monthly per capita basis at a rate equivalent to 95% of the estimated per capita costs of non-HMO (fee-for-service) Medicare beneficiaries in the area. In doing so, Congress sought to provide special incentives to enroll in such Medicare managed care plans, including additional benefits for Medicare beneficiaries and to reward efficient HMOs.

17. In 1982, Congress amended the Social Security Act by enacting the Tax Equity and Fiscal Responsibility Act of 1992, which broadened the types of organizations eligible to contract with the federal government under the Medicare risk program, provided for payment to eligible organizations including HMOs based on a prospective, prepaid, capitated basis, and retained the AAPCC formula. Again, the purpose of this legislation was to assist Medicare beneficiaries, in part by requiring that the participating HMO or other managed care organization must use any profits to benefit beneficiaries by providing additional benefits or services or reducing premiums, deductibles or co-payments for its Medicare plan enrollees.

18. Under the Medicare managed care program, the payments by the federal government to managed care organizations including HMOs are directly related to the AAPCC for a given county. Counties with higher historical fee-for-service costs have a higher AAPCC figure. Therefore, the managed care health plan servicing such counties receives more money per beneficiary from Medicare.

19. AAPCC rates vary greatly. For example, in 1997, the AAPCC rate for Dakota County, Minnesota, was $356.24. In 1997, the AAPCC rate for Richmond County, New York, was $767.35, while in Dade County, Florida, the AAPCC rate was $748.23. In 1997 every county in Minnesota had an AAPCC rate below the national average AAPCC rate.

20. The AAPCC reimbursement formula operated as follows. At the beginning of each year, the AAPCC was compared with an Adjusted Community Rate "ACR." 42 U.S.C. § 1395mm(e)(3). The ACR is essentially a calculation of the insurance premium the plan would charge a commercial customer for providing the Medicare-covered services to the enrollee. 42 U.S.C. § 1395mm(e)(3). This rate could include up to the normal profits and administrative costs that a plan would ordinarily receive in its commercial business, but no more. 42 C.F.R. § 422.310.

21. If the ACR was less than the AAPCC, the plan would receive more money from Medicare than it cost to furnish Medicare-covered services to beneficiaries. In such a case, the plan could choose to (i) receive only the ACR amount from the government, or (ii) contribute all or a portion of the excess money into a stabilization fund, or (iii) provide beneficiaries with additional benefits with a value equal to the difference between the ACR and AAPCC. 42 U.S.C. § 1395mm(g)(2), 42 C.F.R. 422.312.

22. In order to attract enrollees and increase profitability, name recognition, and market share, most plans chose the final option and provided additional benefits to their enrollees. As a result, Medicare beneficiaries who paid into the system in equal proportion, but who reside in areas with lower AAPCC rates under this disparate funding scheme, do not have access to a health plan in their county, or receive fewer health benefits and must pay more for such health benefits than those beneficiaries living in a county with higher AAPCC rates where the health plan provides additional benefits.

23. Congress enacted the Balanced Budget Act of 1997 ("BBA of 1997"), which for the first time altered the AAPCC payment methodology and created the Medicare Part C or "Medicare+Choice" program. Under the BBA of 1997, beginning in 1998, the monthly capitation payments paid to managed care organizations, including HMOs participating in

the newly created Medicare Part C program, or "Medicare+Choice," were to be the greater of the following after adjustment for a national inflation factor:

a) A blended capitation rate, which is the sum of a percentage of a county-specific rate and a percentage of a price-adjusted national rate, multiplied by a budget neutrality factor designed to ensure that the aggregate payments under this blended rate do not exceed the amount that would have been paid under an AAPCC rate alone. 42 U.S.C.A § 1395w-23(c)(1)(a), 42 C.F.R. § 422.252. Even at maximum blending after a phase-in period of five years, only 50% of the geographic funding disparities may be addressed, since only after 2002 would the blended rate consist of a 50% county-based rate and 50% of a national capitation rate.
b) A minimum monthly payment level, which in 1998 equaled $367, multiplied by 12. 42 U.S.C.A. § 1395w-23(c)(1)(b), 42 C.F.R. § 422.252; or
c) A minimum of 102 percent of the previous year's capitation rate. 42 U.S.C.A. § 1395w-23(c)(1)(c), 42 C.F.R. § 422.252.

24. Although the BBA of 1997 altered the monthly capitation rates, the base from which the new amounts were calculated were derived in part from the old disparate rates previously utilized.

25. For the years 1998 and 1999, the BBA of 1997 did not result in the payment of any blended rate amounts to any county. Because the BBA of 1997 provided that the budget neutrality adjustment is applied only to the blended rate, payment for counties that would have received the blended rate were decreased to the point that they were below either the floor payment or the minimum 2% increase. Because the BBA of 1997 provided that payments were to be the greater

of the blended rate, the minimum floor or the minimum 2% increase, no county received a blended rate increase in 1997 or 1998.

26. The legislative purposes of the Medicare Part C included allowing Medicare beneficiaries to have access to a wider array of private health plan choices in addition to traditional fee-for-service Medicare, to expand healthcare delivery options for Medicare beneficiaries and to ensure that such options would be available to beneficiaries nationwide, rather than only in select geographic areas. The new monthly capitation rates and method of calculating these rates is not rationally related to the legislative purpose. In fact, this attempt to expand and provide a wider array of health plan choices and options for Medicare beneficiaries has failed in low AAPCC markets, including in Minnesota, due to the use of the underlying AAPCC calculations.

27. Despite the adoption of the BBA of 1997, Medicare Part C geographic funding disparities under the Medicare managed care program persist.

a. For example, in 1997 the reimbursement level for HMOs serving Hennepin County, Minnesota residents was $405.63 per member per month, while the reimbursement level for HMOs serving residents in Richmond County, New York, was $767.35 per member per month, a difference of $361.72. Under the BBA, both counties received a 2% increase for 1998. This increased the reimbursement rate in Hennepin County to $413.74, following application of the third prong of the BBA capitation formula (the component providing for a 2% increase over the previous year) and increased the Richmond County, New York, reimbursement rate to $782.70. The result was to widen the gap between these illustrative counties to a $368.96 difference.

b. As additional examples, in 1999, the Medicare managed care monthly reimbursement rate for Dakota County, Minnesota, is $394.92. By comparison, the 1999 reimbursement rate for Broward County, Florida, is $676.64; for Los Angeles County, California, $647.70; and for Dade County, Florida, $778.45.

28. Under the BBA of 1997, the foundation of the funding inequities based on the 1997 AAPCC rate has been essentially perpetuated. The underlying fee-for-service data, however, is not rationally related to the costs of managed care. Moreover, a low AAPCC county will remain in that status indefinitely regardless of actual changes in the county's Medicare fee-for-service spending levels in the future.

29. Contrary to the stated legislative purpose, the Medicare managed care reimbursement system, specifically including under Medicare Part C, has restricted the availability and scope of health benefits and increased the cost of benefits for senior citizens in Minnesota participating in the few available Medicare Part C plans. Minnesota health plans have entirely withdrawn from or declined to participate in the Medicare Part C program, or have withdrawn from offering such plans in various counties in Minnesota, or have suffered a reduction in the network of health care providers available to provide medical services to their Medicare plan enrollees. Previously four and currently only three health plans offer Medicare Part C plans to seniors in Minnesota. Such limited Medicare Part C plans are available almost exclusively only in the metropolitan counties in the Minneapolis-St. Paul area and are not generally available to beneficiaries in rural Minnesota counties.

30. The amount of monthly capitation payments made by the federal government to Medicare managed care organizations such as HMOs directly affects the availability of such health plans for Medicare beneficiaries, the premiums

and co-payments charged and the benefits offered to the Medicare beneficiary.

Example Comparison

31. As a result of using an inequitable and irrational funding formula, two Medicare beneficiaries, one living in Broward County, Florida and one in Dakota County, Minnesota, receive vastly different Medicare Part C programs. A comparison is offered below.

Premiums

32. A Medicare Part C enrollee in Dakota County, Minnesota may choose the HealthPartners "Partners for Seniors" - Standard Option ("Minnesota Plan"), after paying the Medicare Part B premium, at an additional annual premium cost of $1,137.

33. A Medicare Part C enrollee in Broward County, Florida, may enroll in the Foundation Health Plan ("Florida Plan"), after paying the Medicare Part B premium, for no additional premium cost.

Benefits/Co-Payments

34. In addition to the vast difference in premium payments, benefits greatly vary under the two plans. For example, the Minnesota beneficiary pays a $10 co-pay per visit with his or her personal physician or specialist doctor. The Florida beneficiary pays no additional co-pay amount.

35. Except for injectable insulin, the Minnesota beneficiary pays all costs for all outpatient prescription drugs. The Florida beneficiary pays nothing for outpatient prescription drugs.

36. The Minnesota beneficiary pays nothing for in-area ambulance transportation but twenty percent for out-of-area ambulance transportation. The Florida beneficiary pays nothing for any transport in an ambulance.

37. The Minnesota beneficiary pays a co-pay of $10 for each individual outpatient mental health session. The Florida beneficiary pays nothing for each individual outpatient mental health session.

38. The Minnesota beneficiary pays a $30 co-payment for emergency services. The Florida beneficiary pays nothing.

39. The Minnesota beneficiary pays $30 for "Urgently Needed Services" in the plan's service area. The Florida resident pays nothing for such services within the plan's service area.

40. Therefore, at the end of a calendar year, the Minnesota beneficiary paid not only significant monthly premium fees but also has paid for all prescription drugs, all ambulance transportation and many co-pay fees, while the Florida beneficiary paid nothing.

41. Typical earnings per capita for Minnesota residents have generally exceeded those of residents in geographic areas with higher AAPCC rates and greater Medicare Part C funding. For example, wages in Broward County, Florida, have historically been 10% to 15% lower than wages in Dakota County, Minnesota. As a result, Minnesota residents contribute higher amounts to Medicare Part A via payroll taxes and contribute higher amounts to Medicare Part B via income taxes. Nevertheless, the Medicare managed care reimbursement scheme described in this complaint provides for the payment of significantly lower, unequal and discriminatory amounts within Minnesota.

VI. CLAIMS FOR RELIEF

First Claim - Violation of the State of Minnesota's Constitutionally Protected Sovereignty

42. Plaintiffs reallege and incorporate by reference the allegations contained in paragraphs 1 through 41 as though fully set forth herein.

43. As a result of defendants' conduct as described in this complaint, the State of Minnesota has suffered harm to its economy, including the loss of hundreds of millions of dollars due to the persistent and systematic funding inequities under the Medicare managed care program.

44. The historic and continuing funding disparities under the Medicare managed care program has required the State to incur significant increased costs in meeting the healthcare needs of its citizens, including senior citizens.

45. The Medicaid program, which is funded in part by the federal government and in part by states, including the State of Minnesota, complements Medicare by assisting approximately 5.4 million low income Medicare beneficiaries nationally by helping them pay Medicare's financial requirements, funding prescription drug coverage and providing for long term care and other services. For fiscal year 1999, the State of Minnesota will spend $503,629,305 in Medicaid funding for the elderly, or approximately 49.34% of the total of $1,041,847,962 in federal (51.66%) and state expenditures for Medicaid funding for the elderly. In fiscal year 1999 the State of Minnesota will spend a total of $17,765,687 in prescription drug spending for the elderly under the Medicaid program.

46. "Dual eligibles" are persons who are entitled to receive Medicare Part A and/or Part B and are also eligible for some form of Medicaid benefits. In Minnesota, there are approximately 600,000 Medicare beneficiaries and 370,000 Medicaid beneficiaries. Of these groups, there are 50,000 Minnesotans who are dually eligible for both Medicare and Medicaid.

47. The level of reimbursement rates under the Medicare managed care program is directly and inversely related to the number of persons likely to be dually eligible for Medicare and Medicaid, thereby affecting state expenditures under the Medicaid program. Beneficiaries who reside in areas in which Medicare managed care capitation payments are lower

and who are eligible for Medicaid are more likely to choose Medicaid (dual eligibility). If Medicare managed care capitation payments are increased, low income Medicare beneficiaries are more likely to enroll in Medicare HMOs and less likely to be dually eligible. Increasing Medicare managed care payments would enable persons to join HMOs for fuller health plan benefits and would reduce the State's Medicaid spending in part because dually eligible beneficiaries would choose to enroll in Medicare HMOs rather than Medicaid.

48. The State legislature has responded to the unmet healthcare needs of its senior citizens in part by enacting a legislative program subsidizing the prescription drug costs of eligible, low income senior citizens in Minnesota. Minn. Stat. §§ 62J.66, 62J.68 (1998). There are approximately 124,600 low income seniors in Minnesota who lack prescription drug coverage. Approximately 51,000 Minnesota seniors may meet the income eligibility guidelines for the state-funded senior drug discount program. The program pays for necessary prescription drugs of income-qualifying seniors, after the enrollee pays an annual enrollment fee and a monthly deductible. The Minnesota legislature appropriated $4.4 million for the senior drug program through June 30, 1999. The Minnesota legislature appropriated $13,502,000 for this program for fiscal year 2000 and $16,182,000 for fiscal year 2001. Total state payments under the senior drug program through September 1999 were $1,012,000 and participating senior citizen enrollees paid $56,000 in premiums under the program.

49. By enacting and implementing the Medicare managed care funding scheme described in this complaint, defendants have abridged and violated the State of Minnesota's inviolate, constitutionally protected sovereignty. Defendants have indirectly but essentially directed State legislative policy and commandeered the State's legislative processes by effectively requiring the State to exercise its

historic police powers to protect public health and welfare by addressing, through legislation and the appropriation of state funds, the unmet healthcare needs of its citizens, including seniors.

50. By enacting and implementing the Medicare managed care funding scheme as described in this complaint, defendants have violated the principle of nondiscrimination that limits the exercise of Congress' legislative powers and that derives from the system of federalism created by the United States Constitution, including but not limited to the Tenth Amendment.

51. Defendants' conduct as described in this complaint violates the State of Minnesota's rights as a sovereign state secured by the system of federalism created and protected by the United States Constitution, including but not limited to the Tenth Amendment.

Second Claim - Equal Protection

52. Plaintiffs reallege and incorporate by reference each and every allegation in paragraphs 1 through 41 as though fully set forth herein.

53. The current reimbursement formula is based on traditional fee-for-service reimbursement rates. The present formula does not bear a relationship to the cost of delivering managed care services in a given community. The current reimbursement formula therefore is not rationally related to the government purpose of expanding health care delivery options to beneficiaries on a nationwide basis.

54. The Medicare managed care funding scheme described in this complaint, specifically including under Medicare Part C, violates the Equal Protection component of the Fifth Amendment to the United States Constitution.

Third Claim - Right To Travel

55. Plaintiffs reallege and incorporate by reference each and every allegation in paragraphs 1 through 41 as though fully set forth herein.

56. The current reimbursement formula creates a Medicare managed care system that penalizes some seniors for exercising their right to travel. Mary Sarno is deterred from and would be penalized for moving from Florida to Minnesota because of the geographic funding disparities for managed care organizations participating in Medicare Part C. The formula is not narrowly tailored to accomplish the government purpose of expanding health care delivery options to beneficiaries on a nationwide basis.

57. The Medicare managed care funding scheme described in this complaint, specifically including under Medicare Part C, violates the fundamental right to travel as guaranteed by the United States Constitution.

Prayer For Relief

WHEREFORE, plaintiffs pray for the following relief:

(1) A declaration that the Medicare managed care payment scheme described in this complaint violates the State of Minnesota's sovereign interests and rights guaranteed under the system of federalism created and protected by the United States Constitution, including without limitation the Tenth Amendment; violates the Equal Protection component of the Due Process Clause of the Fifth Amendment of the United States Constitution; and violates the constitutional right to travel.

(2) An Order enjoining that part of the Medicare managed care funding scheme, specifically including under Medicare Part C, that causes the discriminatory, unequal funding disparities described in this complaint and prohibiting

defendants from continuing to make payments available in a manner that violates the above constitutional rights.

(3) An award to plaintiffs for the costs of this suit and reasonable attorneys fees pursuant to 28 U.S.C. § 2412.

(4) Other such relief as this court may deem just and proper.

Respectfully submitted,

Dated: November 17, 1999

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ATTORNEYS FOR PLAINTIFFS
MINNESOTA SENIOR FEDERATION -
METROPOLITAN REGION AND
MARY SARNO

STATE OF MINNESOTA)
) ss. **AFFIDAVIT OF**
COUNTY OF HENNEPIN) **SERVICE**

Sarah M. Forbes, being first duly sworn, says that on November 17, 1999, City of Minneapolis, County of Hennepin, State of Minnesota, caused to be served **the Summons and Complaint** on the following parties:

VIA CERTIFIED MAIL/ RETURN RECEIPT REQUESTED
Donna E. Shalala
Secretary of Health & Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

VIA CERTIFIED MAIL/ RETURN RECEIPT REQUESTED
Janet Reno, Esq.
U.S. Attorney General
Department of Justice
Constitution Avenue & 10th St., N.W.
Washington, D.C. 20530

by depositing true and correct copies thereof with the U.S. Mail, certified, return receipt requested, addressed to the above-named parties at the above addresses.

s/
Sarah M. Forbes

Subscribed and sworn to before me
this 17th day of November, 1999.

s/ Lynn M. Schmitz
Notary Public

42 U.S.C. § 1395w-21. Eligibility, election, and enrollment

(a) Choice of medicare benefits through Medicare+Choice plans

(1) In general

Subject to the provisions of this section, each Medicare+Choice eligible individual (as defined in paragraph (3)) is entitled to elect to receive benefits under this title--

(A) through the original medicare fee-for-service program under parts A and B of this subchapter, or

(B) through enrollment in a Medicare+Choice plan under this part.

(2) Types of Medicare+Choice plans that may be available

A Medicare+Choice plan may be any of the following types of plans of health insurance:

(A) Coordinated care plans

Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without point of service options), plans offered by provider-sponsored organizations (as defined in section 1395w-25(d) of this title), and preferred provider organization plans.

(B) Combination of MSA plan and contributions to Medicare+Choice MSA

An MSA plan, as defined in section 1395w-28(b)(3) of this title, and a contribution into a Medicare+Choice medical savings account (MSA).

(C) Private fee-for-service plans

A Medicare+Choice private fee-for-service plan, as defined in section 1395w- 28(b)(2) of this title.

(3) Medicare+Choice eligible individual

(A) In general

In this title, subject to subparagraph (B), the term "Medicare+Choice eligible individual" means an individual

who is entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter.

(B) Special rule for end-stage renal disease

Such term shall not include an individual medically determined to have end-stage renal disease, except that--

(i) an individual who develops end-stage renal disease while enrolled in a Medicare+Choice plan may continue to be enrolled in that plan; and

(ii) in the case of such an individual who is enrolled in a Medicare+Choice plan under clause (i) (or subsequently under this clause), if the enrollment is discontinued under circumstances described in subsection (e)(4)(A) of this section, then the individual will be treated as a "Medicare+Choice eligible individual" for purposes of electing to continue enrollment in another Medicare+Choice plan.

(b) Special rules

(1) Residence requirement

(A) In general

Except as the Secretary may otherwise provide and except as provided in subparagraph (C), an individual is eligible to elect a Medicare+Choice plan offered by a Medicare+Choice organization only if the plan serves the geographic area in which the individual resides.

(B) Continuation of enrollment permitted

Pursuant to rules specified by the Secretary, the Secretary shall provide that a plan may offer to all individuals residing in a geographic area the option to continue enrollment in the plan, notwithstanding that the individual no longer resides in the service area of the plan, so long as the plan provides that individuals exercising this option have, as part of the basic benefits described in section 1395w-22(a)(1)(A), reasonable access within that geographic area to the full range of basic benefits, subject to reasonable cost sharing liability in obtaining such benefits.

(C) Continuation of enrollment permitted where service changed

Notwithstanding subparagraph (A) and in addition to subparagraph (B), if a Medicare+Choice organization eliminates from its service area a Medicare+Choice payment area that was previously within its service area, the organization may elect to offer individuals residing in all or portions of the affected area who would otherwise be ineligible to continue enrollment the option to continue enrollment in a Medicare+Choice plan it offers so long as--

(i) the enrollee agrees to receive the full range of basic benefits (excluding emergency and urgently needed care) exclusively at facilities designated by the organization within the plan service area; and

(ii) there is no other Medicare+Choice plan offered in the area in which the enrollee resides at the time of the organization's election.

(2) Special rule for certain individuals covered under FEHBP or eligible for veterans or military health benefits, veterans

(A) FEHBP

An individual who is enrolled in a health benefit plan under chapter 89 of Title 5 [5 U.S.C.A. § 8901 et seq.], is not eligible to enroll in an MSA plan until such time as the Director of the Office of Management and Budget certifies to the Secretary that the Office of Personnel Management has adopted policies which will ensure that the enrollment of such individuals in such plans will not result in increased expenditures for the Federal Government for health benefit plans under such chapter.

(B) VA and DOD

The Secretary may apply rules similar to the rules described in subparagraph (A) in the case of individuals who are eligible for health care benefits under chapter 55 of Title

10 [10 U.S.C.A. § 1071 et seq.], or under chapter 17 of Title 38 [38 U.S.C.A. § 1701 et seq.].

(3) Limitation on eligibility of qualified medicare beneficiaries and other medicaid beneficiaries to enroll in an MSA plan

An individual who is a qualified medicare beneficiary (as defined in section 1396d(p)(1) of this title), a qualified disabled and working individual (described in section 1396d(s) of this title), an individual described in section 1396a(a)(10)(E)(iii) of this title, or otherwise entitled to medicare cost-sharing under a State plan under subchapter XIX of this chapter is not eligible to enroll in an MSA plan.

(4) Coverage under MSA plans on a demonstration basis

(A) In general

An individual is not eligible to enroll in an MSA plan under this part--

(i) on or after January 1, 2003, unless the enrollment is the continuation of such an enrollment in effect as of such date; or

(ii) as of any date if the number of such individuals so enrolled as of such date has reached 390,000.

Under rules established by the Secretary, an individual is not eligible to enroll (or continue enrollment) in an MSA plan for a year unless the individual provides assurances satisfactory to the Secretary that the individual will reside in the United States for at least 183 days during the year.

(B) Evaluation

The Secretary shall regularly evaluate the impact of permitting enrollment in MSA plans under this part on selection (including adverse selection), use of preventive care, access to care, and the financial status of the Trust Funds under this subchapter.

(C) Reports

The Secretary shall submit to Congress periodic reports on the numbers of individuals enrolled in such plans and on the

evaluation being conducted under subparagraph (B). The Secretary shall submit such a report, by not later than March 1, 2002, on whether the time limitation under subparagraph (A)(i) should be extended or removed and whether to change the numerical limitation under subparagraph (A)(ii).

(c) Process for exercising choice

(1) In general

The Secretary shall establish a process through which elections described in subsection (a) are made and changed, including the form and manner in which such elections are made and changed. Such elections shall be made or changed only during coverage election periods specified under subsection (e) of this section and shall become effective as provided in subsection (f) of this section.

(2) Coordination through Medicare+Choice organizations

(A) Enrollment

Such process shall permit an individual who wishes to elect a Medicare+Choice Wan offered by a Medicare+Choice organization to make such election through the filing of an appropriate election form with the organization.

(B) Disenrollment

Such process shall permit an individual, who has elected a Medicare+Choice plan offered by a Medicare+Choice organization and who wishes to terminate such election, to terminate such election through the filing of an appropriate election form with the organization.

(3) Default

(A) Initial election

(i) In general

Subject to clause (ii), an individual who fails to make an election during an initial election period under subsection (e)(1) of this section is deemed to have chosen the original medicare fee-for-service program option.

(ii) Seamless continuation of coverage

The Secretary may establish procedures under which an individual who is enrolled in a health plan (other than Medicare+Choice plan) offered by a Medicare+Choice organization at the time of the initial election period and who fails to elect to receive coverage other than through the organization is deemed to have elected the Medicare+Choice plan offered by the organization (or, if the organization offers more than one such plan, such plan or plans as the Secretary identifies under such procedures).

(B) Continuing periods

An individual who has made (or is deemed to have made) an election under this section is considered to have continued to make such election until such time as--

(i) the individual changes the election under this section, or

(ii) the Medicare+Choice plan with respect to which such election is in effect is discontinued or, subject to subsection (b)(1)(B) of this section, no longer serves the area in which the individual resides.

(d) Providing information to promote informed choice

(1) In general

The Secretary shall provide for activities under this subsection to broadly disseminate information to medicare beneficiaries (and prospective medicare beneficiaries) on the coverage options provided under this section in order to promote an active, informed selection among such options.

(2) Provision of notice

(A) Open season notification

At least 15 days before the beginning of each annual, coordinated election period (as defined in subsection (e)(3)(B) of this section), the Secretary shall mail to each Medicare+Choice eligible individual residing in an area the following:

(i) General information

The general information described in paragraph (3).

(ii) List of plans and comparison of plan options

A list identifying the Medicare+Choice plans that are (or will be) available to residents of the area and information described in paragraph (4) concerning such plans. Such information shall be presented in a comparative form.

(iii) Additional information

Any other information that the Secretary determines will assist the individual in making the election under this section.

The mailing of such information shall be coordinated, to the extent practicable, with the mailing of any annual notice under section 1395b-2 of this title.

(B) Notification to newly eligible Medicare+Choice eligible individuals

To the extent practicable, the Secretary shall, not later than 30 days before the beginning of the initial Medicare+Choice enrollment period for an individual described in subsection (e)(1) of this section, mail to the individual the information described in subparagraph (A).

(C) Form

The information disseminated under this paragraph shall be written and formatted using language that is easily understandable by medicare beneficiaries.

(D) Periodic updating

The information described in subparagraph (A) shall be updated on at least an annual basis to reflect changes in the availability of Medicare+Choice plans and the benefits and Medicare+Choice monthly basic and supplemental beneficiary premiums for such plans.

(3) General information

General information under this paragraph, with respect to coverage under this part during a year, shall include the following:

(A) Benefits under original medicare fee-for-service program option

A general description of the benefits covered under the original medicare fee-for-service program under parts A and B of this subchapter, including--

(i) covered items and services,

(ii) beneficiary cost sharing, such as deductibles, coinsurance, and copayment amounts, and

(iii) any beneficiary liability for balance billing.

(B) Election procedures

Information and instructions on how to exercise election options under this section.

(C) Rights

A general description of procedural rights (including grievance and appeals procedures) of beneficiaries under the original medicare fee-for-service program and the Medicare+Choice program and the right to be protected against discrimination based on health status-related factors under section 1395w- 22(b) of this title.

(D) Information on medigap and medicare select

A general description of the benefits, enrollment rights, and other requirements applicable to medicare supplemental policies under section 1395ss of this title and provisions relating to medicare select policies described in section 1395ss(t) of this title.

(E) Potential for contract termination

The fact that a Medicare+Choice organization may terminate its contract, refuse to renew its contract, or reduce the service area included in its contract, under this part, and the effect of such a termination, nonrenewal, or service area reduction may have on individuals enrolled with the Medicare+Choice plan under this part.

(4) Information comparing plan options

Information under this paragraph, with respect to a Medicare+Choice plan for a year, shall include the following:

(A) Benefits

The benefits covered under the plan, including the following:

(i) Covered items and services beyond those provided under the original medicare fee-for-service program.

(ii) Any beneficiary cost sharing.

(iii) Any maximum limitations on out-of-pocket expenses.

(iv) In the case of an MSA plan, differences in cost sharing, premiums, and balance billing under such a plan compared to under other Medicare+Choice plans.

(v) In the case of a Medicare+Choice private fee-for-service plan, differences in cost sharing, premiums, and balance billing under such a plan compared to under other Medicare+Choice plans.

(vi) The extent to which an enrollee may obtain benefits through out-of- network health care providers.

(vii) The extent to which an enrollee may select among in-network providers and the types of providers participating in the plan's network.

(viii) The organization's coverage of emergency and urgently needed care.

(B) Premiums

The Medicare+Choice monthly basic beneficiary premium and Medicare+Choice monthly supplemental beneficiary premium, if any, for the plan or, in the case of an MSA plan, the Medicare+Choice monthly MSA premium.

(C) Service area

The service area of the plan.

(D) Quality and performance

To the extent available, plan quality and performance indicators for the benefits under the plan (and how they compare to such indicators under the original medicare fee-for-service program under parts A and B of this subchapter in the area involved), including--

(i) disenrollment rates for medicare enrollees electing to receive benefits through the plan for the previous 2 years (excluding disenrollment due to death or moving outside the plan's service area),

(ii) information on medicare enrollee satisfaction,

(iii) information on health outcomes, and

(iv) the recent record regarding compliance of the plan with requirements of this part (as determined by the Secretary).

(E) Supplemental benefits

Whether the organization offering the plan includes mandatory supplemental benefits in its base benefit package or offers optional supplemental benefits and the terms and conditions (including premiums) for such coverage.

(5) Maintaining a toll-free number and Internet site

The Secretary shall maintain a toll-free number for inquiries regarding Medicare+Choice options and the operation of this part in all areas in which Medicare+Choice plans are offered and an Internet site through which individuals may electronically obtain information on such options and Medicare+Choice plans.

(6) Use of non-Federal entities

The Secretary may enter into contracts with non-Federal entities to carry out activities under this subsection.

(7) Provision of information

A Medicare+Choice organization shall provide the Secretary with such information on the organization and each Medicare+Choice plan it offers as may be required for the preparation of the information referred to in paragraph (2)(A).

(e) Coverage election periods

(1) Initial choice upon eligibility to make election if Medicare+Choice plans available to individual

If, at the time an individual first becomes entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter, there is one or more Medicare+Choice plans

offered in the area in which the individual resides, the individual shall make the election under this section during a period specified by the Secretary such that if the individual elects a Medicare+Choice plan during the period, coverage under the plan becomes effective as of the first date on which the individual may receive such coverage.

(2) Open enrollment and disenrollment opportunities Subject to paragraph (5)--

(A) Continuous open enrollment and disenrollment through 2001

At any time during 1998, 1999, 2000, and 2001, a Medicare+Choice eligible individual may change the election under subsection (a)(1).

(B) Continuous open enrollment and disenrollment for first 6 months during 2002

(i) In general

Subject to clause (ii) and subparagraph (D), at any time during the first 6 months of 2002, or, if the individual first becomes a Medicare+Choice eligible individual during 2002, during the first 6 months during 2002 in which the individual is a Medicare+Choice eligible individual, a Medicare+Choice eligible individual may change the election under subsection (a)(1) of this section.

(ii) Limitation of one change

An individual may exercise the right under clause (i) only once. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under the first sentence of paragraph (4).

(C) Continuous open enrollment and disenrollment for first 3 months in subsequent years

(i) In general

Subject to clause (ii) and subparagraph (D), at any time during the first 3 months of a year after 2002, or, if the individual first becomes a Medicare+Choice eligible

individual during a year after 2002, during the first 3 months of such year in which the individual is a Medicare+Choice eligible individual, a Medicare+Choice eligible individual may change the election under subsection (a)(1) if this section.

(ii) Limitation of one change during open enrollment period each year

An individual may exercise the right under clause (i) only once during the applicable 3-month period described in such clause in each year. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under paragraph (4).

(D) Continuous open enrollment for institutionalized individuals

At any time after 2001 in the case of a Medicare+Choice eligible individual who is institutionalized (as defined by the Secretary), the individual may elect under subsection (a)(1)--

(i) to enroll in a Medicare+Choice plan; or

(ii) to change the Medicare+Choice plan in which the individual is enrolled.

(3) Annual, coordinated election period

(A) In general

Subject to paragraph (5), each individual who is eligible to make an election under this section may change such election during an annual, coordinated election period.

(B) Annual, coordinated election period

For purposes of this section, the term "annual, coordinated election period" means, with respect to a calendar year (beginning with 2000), the month of November before such year.

(C) Medicare+Choice health information fairs

During the fall season of each year (beginning with 1999), in conjunction with the annual coordinated election period defined in subparagraph (B), the Secretary shall provide for a

nationally coordinated educational and publicity campaign to inform Medicare+Choice eligible individuals about Medicare+Choice plans and the election process provided under this section.

(D) Special information campaign in 1998

During November 1998 the Secretary shall provide for an educational and publicity campaign to inform Medicare+ Choice eligible individuals about the availability of Medicare+Choice plans, and eligible organizations with risk-sharing contracts under section 1395mm of this title, offered in different areas and the election process provided under this section.

(4) Special election periods

Effective as of January 1, 2002, an individual may discontinue an election of a Medicare+Choice plan offered by a Medicare+Choice organization other than during an annual, coordinated election period and make a new election under this section if--

(A)(i) the certification of the organization or plan under this part has been terminated, or the organization or plan has notified the individual of an impending termination of such certification; or

(ii) the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides, or has notified the individual of an impending termination or discontinuation of such plan;

(B) the individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances (specified by the Secretary, but not including termination of the individual's enrollment on the basis described in clause (i) or (ii) of subsection (g)(3)(B) of this section);

(C) the individual demonstrates (in accordance with guidelines established by the Secretary) that--

(i) the organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual (including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards); or

(ii) the organization (or an agent or other entity acting on the organization's behalf) materially misrepresented the plan's provisions in marketing the plan to the individual; or

(D) the individual meets such other exceptional conditions as the Secretary may provide.

Effective as of January 1, 2002, an individual who, upon first becoming eligible for benefits under part A of this subchapter at age 65, enrolls in a Medicare+Choice plan under this part, the individual may discontinue the election of such plan, and elect coverage under the original fee-for-service plan, at any time during the 12-month period beginning on the effective date of such enrollment.

(5) Special rules for MSA plans

Notwithstanding the preceding provisions of this subsection, an individual--

(A) may elect an MSA plan only during--

(i) an initial open enrollment period described in paragraph (1),

(ii) an annual, coordinated election period described in paragraph (3)(B), or

(iii) the month of November 1998;

(B) subject to subparagraph (C), may not discontinue an election of an MSA plan except during the periods described in clause (ii) or (iii) of subparagraph (A) and under the first sentence of paragraph (4); and

(C) who elects an MSA plan during an annual, coordinated election period, and who never previously had elected such a plan, may revoke such election, in a manner determined by

the Secretary, by not later than December 15 following the date of the election.

(6) Open enrollment periods

Subject to paragraph (5), a Medicare+Choice organization--

(A) shall accept elections or changes to elections during the initial enrollment periods described in paragraph (1), during the month of November 1998 and each subsequent year (as provided in paragraph (3)), and during special election periods described in the first sentence of paragraph (4); and

(B) may accept other changes to elections at such other times as the organization provides.

(f) Effectiveness of elections and changes of elections

(1) During initial coverage election period

An election of coverage made during the initial coverage election period under subsection (e)(1)(A) shall take effect upon the date the individual becomes entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter, except as the Secretary may provide (consistent with section 1395q of this title) in order to prevent retroactive coverage.

(2) During continuous open enrollment periods

An election or change of coverage made under subsection (e)(2) of this section shall take effect with the first day of the first calendar month following the date on which the election or change is made.

(3) Annual, coordinated election period

An election or change of coverage made during an annual, coordinated election period (as defined in subsection (e)(3)(B) of this section) in a year shall take effect as of the first day of the following year.

(4) Other periods

An election or change of coverage made during any other period under subsection (e)(4) of this section shall take effect in such manner as the Secretary provides in a manner

consistent (to the extent practicable) with protecting continuity of health benefit coverage.

(g) Guaranteed issue and renewal

(1) In general

Except as provided in this subsection, a Medicare+Choice organization shall provide that at any time during which elections are accepted under this section with respect to a Medicare+Choice plan offered by the organization, the organization will accept without restrictions individuals who are eligible to make such election.

(2) Priority

If the Secretary determines that a Medicare+Choice organization, in relation to a Medicare+Choice plan it offers, has a capacity limit and the number of Medicare+Choice eligible individuals who elect the plan under this section exceeds the capacity limit, the organization may limit the election of individuals of the plan under this section but only if priority in election is provided--

(A) first to such individuals as have elected the plan at the time of the determination, and

(B) then to other such individuals in such a manner that does not discriminate, on a basis described in section 1395w-22(b) of this title, among the individuals (who seek to elect the plan).

The preceding sentence shall not apply if it would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the medicare population in the service area of the plan.

(3) Limitation on termination of election

(A) In general

Subject to subparagraph (B), a Medicare+Choice organization may not for any reason terminate the election of any individual under this section for a Medicare+Choice plan it offers.

(B) Basis for termination of election

A Medicare+Choice organization may terminate an individual's election under this section with respect to a Medicare+Choice plan it offers if--

(i) any Medicare+Choice monthly basic and supplemental beneficiary premiums required with respect to such plan are not paid on a timely basis (consistent with standards under section 1395w-26 of this title that provide for a grace period for late payment of such premiums),

(ii) the individual has engaged in disruptive behavior (as specified in such standards), or

(iii) the plan is terminated with respect to all individuals under this part in the area in which the individual resides.

(C) Consequence of termination

(i) Terminations for cause

Any individual whose election is terminated under clause (i) or (ii) of subparagraph (B) is deemed to have elected the original medicare fee-for-service program option described in subsection (a)(1)(A) of this section.

(ii) Termination based on plan termination or service area reduction

Any individual whose election is terminated under subparagraph (B)(iii) shall have a special election period under subsection (e)(4)(A) of this section in which to change coverage to coverage under another Medicare+Choice plan. Such an individual who fails to make an election during such period is deemed to have chosen to change coverage to the original medicare fee-for-service program option described in subsection (a)(1)(A) of this section.

(D) Organization obligation with respect to election forms

Pursuant to a contract under section 1395w-27, each Medicare+Choice organization receiving an election form under subsection (c)(2) of this section shall transmit to the Secretary (at such time and in such manner as the Secretary may specify) a copy of such form or such other information respecting the election as the Secretary may specify.

(h) Approval of marketing material and application forms

(1) Submission

No marketing material or application form may be distributed by a Medicare+Choice organization to (or for the use of) Medicare+Choice eligible individuals unless--

(A) at least 45 days (or 10 days in the case described in paragraph (5)) before the date of distribution the organization has submitted the material or form to the Secretary for review, and

(B) the Secretary has not disapproved the distribution of such material or form.

(2) Review

The standards established under section 1395w-26 shall include guidelines for the review of any material or form submitted and under such guidelines the Secretary shall disapprove (or later require the correction of) such material or form if the material or form is materially inaccurate or misleading or otherwise makes a material misrepresentation.

(3) Deemed approval (1-stop shopping)

In the case of material or form that is submitted under paragraph (1)(A) to the Secretary or a regional office of the Department of Health and Human Services and the Secretary or the office has not disapproved the distribution of marketing material or form under paragraph (1)(B) with respect to a Medicare+Choice plan in an area, the Secretary is deemed not to have disapproved such distribution in all other areas covered by the plan and organization except with regard to that portion of such material or form that is specific only to an area involved.

(4) Prohibition of certain marketing practices

Each Medicare+Choice organization shall conform to fair marketing standards, in relation to Medicare+Choice plans offered under this part, included in the standards established under section 1395w-26. Such standards--

(A) shall not permit a Medicare+Choice organization to provide for cash or other monetary rebates as an inducement for enrollment or otherwise, and

(B) may include a prohibition against a Medicare+Choice organization (or agent of such an organization) completing any portion of any election form used to carry out elections under this section on behalf of any individual.

(5) Special treatment of marketing material following model marketing language

In the case of marketing material of an organization that uses, without modification, proposed model language specified by the Secretary, the period specified in paragraph (1)(A) shall be reduced from 45 days to 10 days.

(i) Effect of election of Medicare+Choice plan option

(1) Payments to organizations

Subject to sections 1395w-22(a)(5), 1395w-23(g), 1395w-23(h), 1395ww(d)(11), and 1395ww(h)(3)(D) of this title, payments under a contract with a Medicare+Choice organization under section 1395w-23(a) of this title with respect to an individual electing a Medicare +Choice plan offered by the organization shall be instead of the amounts which (in the absence of the contract) would otherwise be payable under parts A and B of this subchapter for items and services furnished to the individual.

(2) Only organization entitled to payment

Subject to sections 13952w-23(e), 1395w-23(g), 1395w-23(h), 1395w-27(f)(2), 1395ww(d)(11), and 1395ww(h)(3)(D) of this title, only the Medicare+Choice organization shall be entitled to receive payments from the Secretary under this title for services furnished to the individual.

42 U.S.C. § 1395w-22. Benefits and beneficiary protections

(a) Basic benefits

(1) In general

Except as provided in section 1395w-28(b)(3) of this title for MSA plans, each Medicare+Choice plan shall provide to members enrolled under this part, through providers and other persons that meet the applicable requirements of this subchapter and part A of subchapter XI of this chapter

(A) those items and services (other than hospice care) for which benefits are available under parts A and B of this subchapter to individuals residing in the area served by the plan, and

(B) additional benefits required under section 1395w-24(f)(1)(A) of this title.

(2) Satisfaction of requirement

(A) In general

A Medicare+Choice plan (other than an MSA plan) offered by a Medicare+Choice organization satisfies paragraph (1)(A), with respect to benefits for items and services furnished other than through a provider or other person that has a contract with the organization offering the plan, if the plan provides payment in an amount so that--

(i) the sum of such payment amount and any cost sharing provided for under the plan, is equal to at least

(ii) the total dollar amount of payment for such items and services as would otherwise be authorized under parts A and B (including any balance billing permitted under such parts).

(B) Reference to related provisions For provision relating to--

(i) limitations on balance billing against Medicare+Choice organizations for non-contract providers, see subsection (k) of this section and 1395cc(a)(1)(O) of this title, and

(ii) limiting actuarial value of enrollee liability for covered benefits, see section 1395w-24(e) of this title.

(C) Election of uniform coverage policy

In the case of a Medicare+Choice organization that offers a Medicare+Choice plan in an area in which more than one local coverage policy is applied with respect to different parts of the area, the organization may elect to have the local coverage policy for the part of the area that is most beneficial to Medicare+Choice enrollees (as identified by the Secretary) apply with respect to all Medicare +Choice enrollees enrolled in the plan.

(3) Supplemental benefits

(A) Benefits included subject to Secretary's approval

Each Medicare+Choice organization may provide to individuals enrolled under this part, other than under an MSA plan (without affording those individuals an option to decline the coverage), supplemental health care benefits that the Secretary may approve. The Secretary shall approve any such supplemental benefits unless the Secretary determines that including such supplemental benefits would substantially discourage enrollment by Medicare+Choice eligible individuals with the organization.

(B) At enrollees' option

(i) In general

Subject to clause (ii), a Medicare+Choice organization may provide to individuals enrolled under this part supplemental health care benefits that the individuals may elect, at their option, to have covered.

(ii) Special rule for MSA plans

A Medicare+Choice organization may not provide, under an MSA plan, supplemental health care benefits that cover the deductible described in section 1395w-28(b)(2)(B) of this title. In applying the previous sentence, health benefits described in section 1395ss(u)(2)(B) of this title shall not be treated as covering such deductible.

(C) Application to Medicare+Choice private fee-for-service plans

Nothing in this paragraph shall be construed as preventing a Medicare+Choice private fee-for-service plan from offering supplemental benefits that include payment for some or all of the balance billing amounts permitted consistent with subsection (k) of this section and coverage of additional services that the plan finds to be medically necessary.

(4) Organization as secondary payer

Notwithstanding any other provision of law, a Medicare+Choice organization may (in the case of the provision of items and services to an individual under a Medicare+Choice plan under circumstances in which payment under this title is made secondary pursuant to section 1395y(b)(2)) of this title charge or authorize the provider of such services to charge, in accordance with the charges allowed under a law, plan, or policy described in such section--

(A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services, or

(B) such individual to the extent that the individual has been paid under such law, plan, or policy for such services.

(5) National coverage determinations and legislative changes in benefits

If there is a national coverage determination or legislative change in benefits required to be provided under this part made in the period beginning on the date of an announcement under section 1395w-23(b) of this title and ending on the date of the next announcement under such section and the Secretary projects that the determination will result in a significant change in the costs to a Medicare+Choice organization of providing the benefits that are the subject of such national coverage determination and that such change in costs was not incorporated in the determination of the annual

Medicare+Choice capitation rate under section 1395w-23 of this title included in the announcement made at the beginning of such period, then, unless otherwise required by law--

(A) such determination or legislative change in benefits shall not apply to contracts under this part until the first contract year that begins after the end of such period, and

(B) if such coverage determination or legislative change provides for coverage of additional benefits or coverage under additional circumstances, section 1395w-21(i)(1) of this title shall not apply to payment for such additional benefits or benefits provided under such additional circumstances until the first contract year that begins after the end of such period.

The projection under the previous sentence shall be based on an analysis by the Chief Actuary of the Health Care Financing Administration of the actuarial costs associated with the coverage determination or legislative change in benefits.

(b) Antidiscrimination

(1) Beneficiaries

(A) In general

A Medicare+Choice organization may not deny, limit, or condition the coverage or provision of benefits under this part, for individuals permitted to be enrolled with the organization under this part, based on any health status-related factor described in section 300gg-1(a)(1) of this title.

(B) Construction

Subparagraph (A) shall not be construed as requiring a Medicare+Choice organization to enroll individuals who are determined to have end-stage renal disease, except as provided under section 1395w-21(a)(3)(B) of this title.

(2) Providers

A Medicare+Choice organization shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law,

solely on the basis of such license or certification. This paragraph shall not be construed to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan.

(c) Disclosure requirements

(1) Detailed description of plan provisions

A Medicare+Choice organization shall disclose, in clear, accurate, and standardized form to each enrollee with a Medicare+Choice plan offered by the organization under this part at the time of enrollment and at least annually thereafter, the following information regarding such plan:

(A) Service area

The plan's service area.

(B) Benefits

Benefits offered under the plan, including information described in section 1395w-21(d)(3)(A) of this title and exclusions from coverage and, if it is an MSA plan, a comparison of benefits under such a plan with benefits under other Medicare+Choice plans.

(C) Access

The number, mix, and distribution of plan providers, out-of-network coverage (if any) provided by the plan, and any point-of-service option (including the supplemental premium for such option).

(D) Out-of-area coverage

Out-of-area coverage provided by the plan.

(E) Emergency coverage

Coverage of emergency services, including--

(i) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;

(ii) the process and procedures of the plan for obtaining emergency services; and

(iii) the locations of (I) emergency departments, and (II) other settings, in which plan physicians and hospitals provide emergency services and post- stabilization care.

(F) Supplemental benefits

Supplemental benefits available from the organization offering the plan, including--

(i) whether the supplemental benefits are optional,

(ii) the supplemental benefits covered, and

(iii) the Medicare+Choice monthly supplemental beneficiary premium for the supplemental benefits.

(G) Prior authorization rules

Rules regarding prior authorization or other review requirements that could result in nonpayment.

(H) Plan grievance and appeals procedures

All plan appeal or grievance rights and procedures.

(I) Quality assurance program

A description of the organization's quality assurance program under subsection (e).

(2) Disclosure upon request

Upon request of a Medicare+Choice eligible individual, a Medicare+Choice organization must provide the following information to such individual:

(A) The general coverage information and general comparative plan information made available under clauses (i) and (ii) of section 1395w- 21(d)(2)(A) of this title.

(B) Information on procedures used by the organization to control utilization of services and expenditures.

(C) Information on the number of grievances, redeterminations, and appeals and on the disposition in the aggregate of such matters.

(D) An overall summary description as to the method of compensation of participating physicians.

(d) Access to services

(1) In general

A Medicare+Choice organization offering a Medicare+ Choice plan may select the providers from whom the benefits under the plan are provided so long as--

(A) the organization makes such benefits available and accessible to each individual electing the plan within the plan service area with reasonable promptness and in a manner which assures continuity in the provision of benefits;

(B) when medically necessary the organization makes such benefits available and accessible 24 hours a day and 7 days a week;

(C) the plan provides for reimbursement with respect to services which are covered under subparagraphs (A) and (B) and which are provided to such an individual other than through the organization, if--

(i) the services were not emergency services (as defined in paragraph (3)), but (I) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition, and (II) it was not reasonable given the circumstances to obtain the services through the organization,

(ii) the services were renal dialysis services and were provided other than through the organization because the individual was temporarily out of the plan's service area, or

(iii) the services are maintenance care or post-stabilization care covered under the guidelines established under paragraph (2);

(D) the organization provides access to appropriate providers, including credentialed specialists, for medically necessary treatment and services; and

(E) coverage is provided for emergency services (as defined in paragraph (3)) without regard to prior authorization or the emergency care provider's contractual relationship with the organization.

(2) Guidelines respecting coordination of post-stabilization care

A Medicare+Choice plan shall comply with such guidelines as the Secretary may prescribe relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care of an enrollee after the enrollee has been determined to be stable under section 1395dd of this title.

(3) Definition of emergency services

In this subsection

(A) In general

The term "emergency services" means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that--

(i) are furnished by a provider that is qualified to furnish such services under this title, and

(ii) are needed to evaluate or stabilize an emergency medical condition (as defined in subparagraph (B)).

(B) Emergency medical condition based on prudent layperson

The term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in--

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part.

(4) Assuring access to services in Medicare+Choice private fee-for-service plans

In addition to any other requirements under this part, in the case of a Medicare+Choice private fee-for-service plan, the organization offering the plan must demonstrate to the

Secretary that the organization has sufficient number and range of health care professionals and providers willing to provide services under the terms of the plan. The Secretary shall find that an organization has met such requirement with respect to any category of health care professional or provider if, with respect to that category of provider--

(A) the plan has established payment rates for covered services furnished by that category of provider that are not less than the payment rates provided for under part A of this subchapter, part B of this subchapter, or both, for such services, or

(B) the plan has contracts or agreements with a sufficient number and range of providers within such category to provide covered services under the terms of the plan, or a combination of both. The previous sentence shall not be construed as restricting the persons from whom enrollees under such a plan may obtain covered benefits.

(e) Quality assurance program

(1) In general

Each Medicare+Choice organization must have arrangements, consistent with any regulation, for an ongoing quality assurance program for health care services it provides to individuals enrolled with Medicare+Choice plans of the organization.

(2) Elements of program

(A) In general

The quality assurance program of an organization with respect to a Medicare+Choice plan (other than a Medicare+Choice private fee-for-service plan, a non-network MSA plan, or a preferred provider organization plan) it offers shall--

(i) stress health outcomes and provide for the collection, analysis, and reporting of data (in accordance with a quality measurement system that the Secretary recognizes) that will

permit measurement of outcomes and other indices of the quality of Medicare+Choice plans and organizations;

(ii) monitor and evaluate high volume and high risk services and the care of acute and chronic conditions;

(iii) evaluate the continuity and coordination of care that enrollees receive;

(iv) be evaluated on an ongoing basis as to its effectiveness;

(v) include measures of consumer satisfaction;

(vi) provide the Secretary with such access to information collected as may be appropriate to monitor and ensure the quality of care provided under this part;

(vii) provide review by physicians and other health care professionals of the process followed in the provision of such health care services;

(viii) provide for the establishment of written protocols for utilization review, based on current standards of medical practice;

(ix) have mechanisms to detect both underutilization and overutilization of services;

(x) after identifying areas for improvement, establish or alter practice parameters;

(xi) take action to improve quality and assesses the effectiveness of such action through systematic followup; and

(xii) make available information on quality and outcomes measures to facilitate beneficiary comparison and choice of health coverage options (in such form and on such quality and outcomes measures as the Secretary determines to be appropriate).

Such program shall include a separate focus (with respect to all the elements described in this subparagraph) on racial and ethnic minorities.

(B) Elements of program for organizations offering Medicare+Choice private fee-for-service plans, non-network MSA plans, and preferred provider organization plans

The quality assurance program of an organization with respect to a Medicare+Choice private fee-for-service plan, a non-network MSA plan, or a preferred provider organization plan it offers shall--

(i) meet the requirements of clauses (i) through (vi) of subparagraph (A);

(ii) insofar as it provides for the establishment of written protocols for utilization review, base such protocols on current standards of medical practice; and

(iii) have mechanisms to evaluate utilization of services and inform providers and enrollees of the results of such evaluation.

Such program shall include a separate focus (with respect to all the elements described in this subparagraph) on racial and ethnic minorities.

(C) Definition of non-network MSA plan

In this subsection, the term "non-network MSA plan" means an MSA plan offered by a Medicare+Choice organization that does not provide benefits required to be provided by this part, in whole or in part, through a defined set of providers under contract, or under another arrangement, with the organization.

(D) Definition of preferred provider organization plan

In this paragraph, the term "preferred provider organization plan" means a Medicare+Choice plan that--

(i) has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan;

(ii) provides for reimbursement for all covered benefits regardless of whether such benefits are provided within such network of providers; and

(iii) is offered by an organization that is not licensed or organized under State law as a health maintenance organization.

(3) External review

(A) In general

Each Medicare+Choice organization shall, for each Medicare+Choice plan it operates, have an agreement with an independent quality review and improvement organization approved by the Secretary to perform functions of the type described in sections 1320c-3(a)(4)(B) and 1320c-3(a)(14) of this title with respect to services furnished by Medicare+ Choice plans for which payment is made under this title. The previous sentence shall not apply to a Medicare+Choice private fee-for-service plan or a non-network MSA plan that does not employ utilization review.

(B) Nonduplication of accreditation

Except in the case of the review of quality complaints, and consistent with subparagraph (C), the Secretary shall ensure that the external review activities conducted under subparagraph (A) are not duplicative of review activities conducted as part of the accreditation process.

(C) Waiver authority

The Secretary may waive the requirement described in subparagraph (A) in the case of an organization if the Secretary determines that the organization has consistently maintained an excellent record of quality assurance and compliance with other requirements under this part.

(4) Treatment of accreditation

(A) In general

The Secretary shall provide that a Medicare+Choice organization is deemed to meet all the requirements described in any specific clause of subparagraph (B) if the organization is accredited (and periodically reaccredited) by a private accrediting organization under a process that the Secretary has determined assures that the accrediting organization applies and enforces standards that meet or exceed the standards established under section 1395w- 26 of this title to carry out the requirements in such clause.

(B) Requirements described

The provisions described in this subparagraph are the following:

(i) Paragraphs (1) and (2) of this subsection (relating to quality assurance programs).

(ii) Subsection (b) (relating to antidiscrimination).

(iii) Subsection (d) (relating to access to services).

(iv) Subsection (h) (relating to confidentiality and accuracy of enrollee records).

(v) Subsection (i) (relating to information on advance directives).

(vi) Subsection (j) (relating to provider participation rules).

(C) Timely action on applications

The Secretary shall determine, within 210 days after the date the Secretaryreceives an application by a private accrediting organization and using the criteria specified in section 1395bb(b)(2) of this title, whether the process of the private accrediting organization meets the requirements with respect to any specific clause in subparagraph (B) with respect to which the application is made. The Secretary may not deny such an application on the basis that it seeks to meet the requirements with respect to only one, or more than one, such specific clause.

(D) Construction

Nothing in this paragraph shall be construed as limiting the authority of the Secretary under section 1395w-27 of this title, including the authority to terminate contracts with Medicare+Choice organizations under subsection (c)(2) of such section.

(5) Report to Congress

(A) In general

Not later than 2 years after December 21, 2000, and biennially thereafter, the Secretary shall submit to Congress a report regarding how quality assurance programs conducted under this subsection focus on racial and ethnic minorities.

(B) Contents of report

Each such report shall include the following:

(i) A description of the means by which such programs focus on such racial and ethnic minorities.

(ii) An evaluation of the impact of such programs on eliminating health disparities and on improving health outcomes, continuity and coordination of care, management of chronic conditions, and consumer satisfaction.

(iii) Recommendations on ways to reduce clinical outcome disparities among racial and ethnic minorities.

(f) Grievance mechanism

Each Medicare+Choice organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and enrollees with Medicare+Choice plans of the organization under this part.

(g) Coverage determinations, reconsiderations, and appeals

(1) Determinations by organization

(A) In general

A Medicare+Choice organization shall have a procedure for making determinations regarding whether an individual enrolled with the plan of the organization under this part is entitled to receive a health service under this section and the amount (if any) that the individual is required to pay with respect to such service. Subject to paragraph (3), such procedures shall provide for such determination to be made on a timely basis.

(B) Explanation of determination

Such a determination that denies coverage, in whole or in part, shall be in writing and shall include a statement in understandable language of the reasons for the denial and a description of the reconsideration and appeals processes.

(2) Reconsiderations

(A) In general

The organization shall provide for reconsideration of a determination described in paragraph (1)(B) upon request by the enrollee involved. The reconsideration shall be within a time period specified by the Secretary, but shall be made, subject to paragraph (3), not later than 60 days after the date of the receipt of the request for reconsideration.

(B) Physician decision on certain reconsiderations

A reconsideration relating to a determination to deny coverage based on a lack of medical necessity shall be made only by a physician with appropriate expertise in the field of medicine which necessitates treatment who is other than a physician involved in the initial determination.

(3) Expedited determinations and reconsiderations

(A) Receipt of requests

(i) Enrollee requests

An enrollee in a Medicare+Choice plan may request, either in writing or orally, an expedited determination under paragraph (1) or an expedited reconsideration under paragraph (2) by the Medicare+Choice organization.

(ii) Physician requests

A physician, regardless whether the physician is affiliated with the organization or not, may request, either in writing or orally, such an expedited determination or reconsideration.

(B) Organization procedures

(i) In general

The Medicare+Choice organization shall maintain procedures for expediting organization determinations and reconsiderations when, upon request of an enrollee, the organization determines that the application of the normal time frame for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

(ii) Expedition required for physician requests

In the case of a request for an expedited determination or reconsideration made under subparagraph (A)(ii), the organization shall expedite the determination or reconsideration if the request indicates that the application of the normal time frame for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

(iii) Timely response

In cases described in clauses (i) and (ii), the organization shall notify the enrollee (and the physician involved, as appropriate) of the determination or reconsideration under time limitations established by the Secretary, but not later than 72 hours of the time of receipt of the request for the determination or reconsideration (or receipt of the information necessary to make the determination or reconsideration), or such longer period as the Secretary may permit in specified cases.

(4) Independent review of certain coverage denials

The Secretary shall contract with an independent, outside entity to review and resolve in a timely manner reconsiderations that affirm denial of coverage, in whole or in part.

(5) Appeals

An enrollee with a Medicare+Choice plan of a Medicare+Choice organization under this part who is dissatisfied by reason of the enrollee's failure to receive any health service to which the enrollee believes the enrollee is entitled and at no greater charge than the enrollee believes the enrollee is required to pay is entitled, if the amount in controversy is $100 or more, to a hearing before the Secretary to the same extent as is provided in section 405(b) of this title, and in any such hearing the Secretary shall make the organization a party. If the amount in controversy is $1,000 or more, the individual or organization shall, upon notifying

the other party, be entitled to judicial review of the Secretary's final decision as provided in section 405(g) of this title, and both the individual and the organization shall be entitled to be parties to that judicial review. In applying subsections (b) and (g) of section 405 of this title as provided in this paragraph, and in applying section 405(1) of this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

(h) Confidentiality and accuracy of enrollee records

Insofar as a Medicare+Choice organization maintains medical records or other health information regarding enrollees under this part, the Medicare+Choice organization shall establish procedures--

(1) to safeguard the privacy of any individually identifiable enrollee information;

(2) to maintain such records and information in a manner that is accurate and timely; and

(3) to assure timely access of enrollees to such records and information.

(i) Information on advance directives

Each Medicare+Choice organization shall meet the requirement of section 1395cc(f) of this title (relating to maintaining written policies and procedures respecting advance directives).

(j) Rules regarding provider participation

(1) Procedures

Insofar as a Medicare+Choice organization offers benefits under a Medicare+Choice plan through agreements with physicians, the organization shall establish reasonable procedures relating to the participation (under an agreement between a physician and the organization) of physicians under such a plan. Such procedures shall include--

(A) providing notice of the rules regarding participation,

(B) providing written notice of participation decisions that are adverse to physicians, and

(C) providing a process within the organization for appealing such adverse decisions, including the presentation of information and views of the physician regarding such decision.

(2) Consultation in medical policies

A Medicare+Choice organization shall consult with physicians who have entered into participation agreements with the organization regarding the organization's medical policy, quality, and medical management procedures.

(3) Prohibiting interference with provider advice to enrollees

(A) In general

Subject to subparagraphs (B) and (C), a Medicare+Choice organization (in relation to an individual enrolled under a Medicare+Choice plan offered by the organization under this part) shall not prohibit or otherwise restrict a covered health care professional (as defined in subparagraph (D)) from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan, if the professional is acting within the lawful scope of practice.

(B) Conscience protection

Subparagraph (A) shall not be construed as requiring a Medicare+Choice plan to provide, reimburse for, or provide coverage of a counseling or referral service if the Medicare+Choice organization offering the plan--

(i) objects to the provision of such service on moral or religious grounds; and

(ii) in the manner and through the written instrumentalities such Medicare+Choice organization deems appropriate, makes available information on its policies regarding such service to prospective enrollees before or

during enrollment and to enrollees within 90 days after the date that the organization or plan adopts a change in policy regarding such a counseling or referral service.

(C) Construction

Nothing in subparagraph (B) shall be construed to affect disclosure requirements under State law or under the Employee Retirement Income Security Act of 1974.

(D) Health care professional defined

For purposes of this paragraph, the term "health care professional" means a physician (as defined in section 1395x(r)) or other health care professional if coverage for the professional's services is provided under the Medicare+Choice plan for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

(4) Limitations on physician incentive plans

(A) In general

No Medicare+Choice organization may operate any physician incentive plan (as defined in subparagraph (B)) unless the following requirements are met:

(i) No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the organization.

(ii) If the plan places a physician or physician group at substantial financial risk (as determined by the Secretary)

for services not provided by the physician or physician group, the organization--

(I) provides stop-loss protection for the physician or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of physicians placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or group, and

(II) conducts periodic surveys of both individuals enrolled and individuals previously enrolled with the organization to determine the degree of access of such individuals to services provided by the organization and satisfaction with the quality of such services.

(iii) The organization provides the Secretary with descriptive information regarding the plan, sufficient to permit the Secretary to determine whether the plan is in compliance with the requirements of this subparagraph.

(B) Physician incentive plan defined

In this paragraph, the term "physician incentive plan" means any compensation arrangement between a Medicare+Choice organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization under this part.

(5) Limitation on provider indemnification

A Medicare+Choice organization may not provide (directly or indirectly) for a health care professional, provider of services, or other entity providing health care services (or group of such professionals, providers, or entities) to indemnify the organization against any liability resulting from a civil action brought for any damage caused to an enrollee with a Medicare+Choice plan of the organization under this part by the organization's denial of medically necessary care.

(6) Special rules for Medicare+Choice private fee-for-service plans

For purposes of applying this part (including subsection (k)(1)) and section 1395cc(a)(1)(O) of this title, a hospital (or other provider of services), a physician or other health care professional, or other entity furnishing health care services is treated as having an agreement or contract in effect with a Medicare+Choice organization (with respect to an individual enrolled in a Medicare+Choice private fee-for-service plan it offers), if--

(A) the provider, professional, or other entity furnishes services that are covered under the plan to such an enrollee; and

(B) before providing such services, the provider, professional, or other entity--

(i) has been informed of the individual's enrollment under the plan, and

(ii) either--

(I) has been informed of the terms and conditions of payment for such services under the plan, or

(II) is given a reasonable opportunity to obtain information concerning such terms and conditions, in a manner reasonably designed to effect informed agreement by a provider.

The previous sentence shall only apply in the absence of an explicit agreement between such a provider, professional, or other entity and the Medicare+Choice organization.

(k) Treatment of services furnished by certain providers

(1) In general

Except as provided in paragraph (2), a physician or other entity (other than a provider of services) that does not have a contract establishing payment amounts for services furnished to an individual enrolled under this part with a Medicare+Choice organization described in section 1395w-21(a)(2)(A) of this title shall accept as payment in full for

covered services under this title that are furnished to such an individual the amounts that the physician or other entity could collect if the individual were not so enrolled. Any penalty or other provision of law that applies to such a payment with respect to an individual entitled to benefits under this subchapter (but not enrolled with a Medicare+Choice organization under this part) also applies with respect to an individual so enrolled.

(2) Application to Medicare+Choice private fee-for-service plans

(A) Balance billing limits under Medicare+Choice private fee-for-service plans in case of contract providers

(i) In general

In the case of an individual enrolled in a Medicare+Choice private fee-for-service plan under this part, a physician, provider of services, or other entity that has a contract (including through the operation of subsection (j)(6) of this section) establishing a payment rate for services furnished to the enrollee shall accept as payment in full for covered services under this title that are furnished to such an individual an amount not to exceed (including any deductibles, coinsurance, copayments, or balance billing otherwise permitted under the plan) an amount equal to 115 percent of such payment rate.

(ii) Procedures to enforce limits

The Medicare+Choice organization that offers such a plan shall establish procedures, similar to the procedures described in section 1395w-4(g)(1)(A) of this title, in order to carry out the previous sentence.

(iii) Assuring enforcement

If the Medicare+Choice organization fails to establish and enforce procedures required under clause (ii), the organization is subject to intermediate sanctions under section 1395w-27(g) of this title.

(B) Enrollee liability for noncontract providers

For provision--

(i) establishing minimum payment rate in the case of noncontract providers under a Medicare+Choice private fee-for-service plan, see section 1395w- 22(a)(2) of this title; or

(ii) limiting enrollee liability in the case of covered services furnished by such providers, see paragraph (1) and section 1395cc(a)(1)(O) of this title.

(C) Information on beneficiary liability

(i) In general

Each Medicare+Choice organization that offers a Medicare+Choice private fee-for-service plan shall provide that enrollees under the plan who are furnished services for which payment is sought under the plan are provided an appropriate explanation of benefits (consistent with that provided under parts A and B of this subchapter and, if applicable, under medicare supplemental policies) that includes a clear statement of the amount of the enrollee's liability (including any liability for balance billing consistent with this subsection) with respect to payments for such services.

(ii) Advance notice before receipt of inpatient hospital services and certain other services

In addition, such organization shall, in its terms and conditions of payments to hospitals for inpatient hospital services and for other services identified by the Secretary for which the amount of the balance billing under subparagraph (A) could be substantial, require the hospital to provide to the enrollee, before furnishing such services and if the hospital imposes balance billing under subparagraph (A)--

(I) notice of the fact that balance billing is permitted under such subparagraph for such services, and

(II) a good faith estimate of the likely amount of such balance billing (if any), with respect to such services, based upon the presenting condition of the enrollee.

(l) Return to home skilled nursing facilities for covered post-hospital extended care services

(1) Ensuring return to home SNF

(A) In general

In providing coverage of post-hospital extended care services, a Medicare+Choice plan shall provide for such coverage through a home skilled nursing facility if the following conditions are met:

(i) Enrollee election

The enrollee elects to receive such coverage through such facility.

(ii) SNF agreement

The facility has a contract with the Medicare+Choice organization for the provision of such services, or the facility agrees to accept substantially similar payment under the same terms and conditions that apply to similarly situated skilled nursing facilities that are under contract with the Medicare+Choice organization for the provision of such services and through which the enrollee would otherwise receive such services.

(B) Manner of payment to home SNF

The organization shall provide payment to the home skilled nursing facility consistent with the contract or the agreement described in subparagraph (A)(ii), as the case may be.

(2) No less favorable coverage

The coverage provided under paragraph (1) (including scope of services, cost- sharing, and other criteria of coverage) shall be no less favorable to the enrollee than the coverage that would be provided to the enrollee with respect to a skilled nursing facility the post-hospital extended care services of which are otherwise covered under the Medicare+Choice plan.

(3) Rule of construction

Nothing in this subsection shall be construed to do the following:

(A) To require coverage through a skilled nursing facility that is not otherwise qualified to provide benefits under part A of this subchapter for medicare beneficiaries not enrolled in a Medicare+Choice plan.

(B) To prevent a skilled nursing facility from refusing to accept, or imposing conditions upon the acceptance of, an enrollee for the receipt of post-hospital extended care services.

(4) Definitions

In this subsection:

(A) Home skilled nursing facility

The term "home skilled nursing facility" means, with respect to an enrollee who is entitled to receive post-hospital extended care services under a Medicare+Choice plan, any of the following skilled nursing facilities:

(i) SNF residence at time of admission

The skilled nursing facility in which the enrollee resided at the time of admission to the hospital preceding the receipt of such post-hospital extended care services.

(ii) SNF in continuing care retirement community

A skilled nursing facility that is providing such services through a continuing care retirement community (as defined in subparagraph (B)) which provided residence to the enrollee at the time of such admission.

(iii) SNF residence of spouse at time of discharge

The skilled nursing facility in which the spouse of the enrollee is residing at the time of discharge from such hospital.

(B) Continuing care retirement community

The term "continuing care retirement community" means, with respect to an enrollee in a Medicare+Choice plan, an arrangement under which housing and health-related services are provided (or arranged) through an organization for the

enrollee under an agreement that is effective for the life of the enrollee or for a specified period.

42 U.S.C. § 1395w-23. Payments to Medicare+Choice organizations

(a) Payments to organizations

(1) Monthly payments

(A) In general

Under a contract under section 1395w-27 of this title and subject to subsections (e), (g), and (i) of this section and section 1395w-28(e)(4) of this title, the Secretary shall make monthly payments under this section in advance to each Medicare+Choice organization, with respect to coverage of an individual under this part in a Medicare+Choice payment area for a month, in an amount equal to 1/12 of the annual Medicare+Choice capitation rate (as calculated under subsection (c) of this section) with respect to that individual for that area, adjusted for such risk factors as age, disability status, gender, institutional status, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such factors, if such changes will improve the determination of actuarial equivalence.

(B) Special rule for end-stage renal disease

The Secretary shall establish separate rates of payment to a Medicare+Choice organization with respect to classes of individuals determined to have end-stage renal disease and enrolled in a Medicare+Choice plan of the organization. Such rates of payment shall be actuarially equivalent to rates paid to other enrollees in the Medicare+Choice payment area (or such other area as specified by the Secretary). In accordance with regulations, the Secretary shall provide for the application of the seventh sentence of section 1395rr(b)(7) of this title to payments under this section covering the provision of renal dialysis treatment in the same manner as such sentence applies to composite rate payments described in such sentence. In establishing such rates, the Secretary shall

provide for appropriate adjustments to increase each rate to reflect the demonstration rate (including the risk adjustment methodology associated with such rate) of the social health maintenance organization end-stage renal disease capitation demonstrations (established by section 2355 of the Deficit Reduction Act of 1984, as amended by section 13567(b) of the Omnibus Budget Reconciliation Act of 1993), and shall compute such rates by taking into account such factors as renal treatment modality, age, and the underlying cause of the end-stage renal disease.

(2) Adjustment to reflect number of enrollees

(A) In general

The amount of payment under this subsection may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled with an organization under this part and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

(B) Special rule for certain enrollees

(i) In general

Subject to clause (ii), the Secretary may make retroactive adjustments under subparagraph (A) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with a Medicare+Choice organization under a plan operated, sponsored, or contributed to by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the organization under this part, except that for purposes of making such retroactive adjustments under this subparagraph, such period may not exceed 90 days.

(ii) Exception

No adjustment may be made under clause (i) with respect to any individual who does not certify that the organization provided the individual with the disclosure statement

described in section 1395w-22(c) of this title at the time the individual enrolled with the organization.

(3) Establishment of risk adjustment factors

(A) Report

The Secretary shall develop, and submit to Congress by not later than March 1, 1999, a report on the method of risk adjustment of payment rates under this section, to be implemented under subparagraph (C), that accounts for variations in per capita costs based on health status. Such report shall include an evaluation of such method by an outside, independent actuary of the actuarial soundness of the proposal.

(B) Data collection

In order to carry out this paragraph, the Secretary shall require Medicare+Choice organizations (and eligible organizations with risk-sharing contracts under section 1395mm of this title) to submit data regarding inpatient hospital services for periods beginning on or after July 1, 1997, and data regarding other services and other information as the Secretary deems necessary for periods beginning on or after July 1, 1998. The Secretary may not require an organization to submit such data before January 1, 1998.

(C) Initial implementation

(i) In general

The Secretary shall first provide for implementation of a risk adjustment methodology that accounts for variations in per capita costs based on health status and other demographic factors for payments by no later than January 1, 2000.

(ii) Phase-in

Except as provided in clause (iii), such risk adjustment methodology shall be implemented in a phased-in manner so that the methodology insofar as it makes adjustments to capitation rates for health status applies to--

(I) 10 percent of 1/12 of the annual Medicare+Choice capitation rate in 2000 and each succeeding year through 2003;

(II) 30 percent of such capitation rate in 2004;

(III) 50 percent of such capitation rate in 2005;

(IV) 75 percent of such capitation rate in 2006; and

(V) 100 percent of such capitation rate in 2007 and succeeding years.

(iii) [FN1]Data for risk adjustment methodology

Such risk adjustment methodology for 2004 and each succeeding year, shall be based on data from inpatient hospital and ambulatory settings.

(iii) [FN1] Full implementation of risk adjustment for congestive heart failure enrollees for 2001

(I) Exemption from phase-in

Subject to subclause (II), the Secretary shall fully implement the risk adjustment methodology described in clause (i) with respect to each individual who has had a qualifying congestive heart failure inpatient diagnosis (as determined by the Secretary under such risk adjustment methodology) during the period beginning on July 1, 1999, and ending on June 30, 2000, and who is enrolled in a coordinated care plan that is the only coordinated care plan offered on January 1, 2001, in the service area of the individual.

(II) Period of application

Subclause (I) shall only apply during the 1-year period beginning on January 1, 2001.

(D) Uniform application to all types of plans

Subject to section 1395w-28(e)(4) of this title, the methodology shall be applied uniformly without regard to the type of plan.

(b) Annual announcement of payment rates

(1) Annual announcement

The Secretary shall annually determine, and shall announce (in a manner intended to provide notice to interested parties) not later than March 1 before the calendar year concerned--

(A) the annual Medicare+Choice capitation rate for each Medicare+Choice payment area for the year, and

(B) the risk and other factors to be used in adjusting such rates under subsection (a)(1)(A) of this section for payments for months in that year.

(2) Advance notice of methodological changes

At least 45 days before making the announcement under paragraph (1) for a year, the Secretary shall provide for notice to Medicare+Choice organizations of proposed changes to be made in the methodology from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity to comment on such proposed changes.

(3) Explanation of assumptions

In each announcement made under paragraph (1), the Secretary shall include an explanation of the assumptions and changes in methodology used in the announcement in sufficient detail so that Medicare+Choice organizations can compute monthly adjusted Medicare+Choice capitation rates for individuals in each Medicare+Choice payment area which is in whole or in part within the service area of such an organization.

(4) Continued computation and publication of county-specific per capita fee-for-service expenditure information

The Secretary, through the Chief Actuary of the Health Care Financing Administration, shall provide for the computation and publication, on an annual basis beginning with 2001 at the time of publication of the annual Medicare+Choice capitation rates under paragraph (I), of the following information for the original medicare fee-for-service program under parts A and B of this subchapter [42 U.S.C.A. §§ 1395c et seq. and 1395j et seq.] (exclusive of individuals eligible for

coverage under section 426-1 of this title) for each Medicare+Choice payment area for the second calendar year ending before the date of publication:

(A) Total expenditures per capita per month, computed separately for part A of this subchapter [42 U.S.C.A. § 1395c et seq.] and for part B of this subchapter [42 U.S.C.A. § 1395j et seq.].

(B) The expenditures described in subparagraph (A) reduced by the best estimate of the expenditures (such as graduate medical education and disproportionate share hospital payments) not related to the payment of claims.

(C) The average risk factor for the covered population based on diagnoses reported for medicare inpatient services, using the same methodology as is expected to be applied in making payments under subsection (a).

(D) Such average risk factor based on diagnoses for inpatient and other sites of service, using the same methodology as is expected to be applied in making payments under subsection (a).

(c) Calculation of annual Medicare+Choice capitation rates

(1) In general

For purposes of this part, subject to paragraphs (6)(C) and (7), each annual Medicare+Choice capitation rate, for a Medicare+Choice payment area for a contract year consisting of a calendar year, is equal to the largest of the amounts specified in the following subparagraph (A), (B), or (C):

(A) Blended capitation rate

The sum of--

(i) the area-specific percentage (as specified under paragraph (2) for the year) of the annual area-specific Medicare+Choice capitation rate for the Medicare+Choice payment area, as determined under paragraph (3) for the year, and

(ii) the national percentage (as specified under paragraph (2) for the year) of the input-price-adjusted annual national

Medicare+Choice capitation rate, as determined under paragraph (4) for the year, multiplied by the budget neutrality adjustment factor determined under paragraph (5).

(B) Minimum amount

12 multiplied by the following amount:

(i) For I998, $367 (but not to exceed, in the case of an area outside the 50 States and the District of Columbia, 150 percent of the annual per capita rate of payment for 1997 determined under section 1395mm(a)(1)(C) of this title for the area).

(ii) For 1999 and 2000, the minimum amount determined under clause (i) or this clause, respectively, for the preceding year, increased by the national per capita Medicare+Choice growth percentage described in paragraph (6)(A) applicable to 1999 or 2000, respectively.

(iii)(I) Subject to subclause (II), for 2001, for any area in a Metropolitan Statistical Area with a population of more than 250,000, $525, and for any other area $475.

(II) In the case of an area outside the 50 States and the District of Columbia, the amount specified in this clause shall not exceed 120 percent of the amount determined under clause (ii) for such area for 2000.

(iv) For 2002 and each succeeding year, the minimum amount specified in this clause (or clause (iii)) for the preceding year increased by the national per capita Medicare+Choice growth percentage, described in paragraph (6)(A) for that succeeding year.

(C) Minimum percentage increase

(i) For 1998, 102 percent of the annual per capita rate of payment for 1997 determined under section 1395mm(a)(1)(C) of this title for the Medicare+Choice payment area.

(ii) For 1999 and 2000, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

(iii) For 2001, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for 2000.

(iv) For 2002 and each succeeding year, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

(2) Area-specific and national percentages For purposes of paragraph (1)(A)--

(A) for 1998, the "area-specific percentage" is 90 percent and the "national percentage" is 10 percent,

(B) for 1999, the "area-specific percentage" is 82 percent and the "national percentage" is 18 percent,

(C) for 2000, the "area-specific percentage" is 74 percent and the "national percentage" is 26 percent,

(D) for 2001, the "area-specific percentage" is 66 percent and the "national percentage" is 34 percent,

(E) for 2002, the "area-specific percentage" is 58 percent and the "national percentage" is 42 percent, and

(F) for a year after 2002, the "area-specific percentage" is 50 percent and the "national percentage" is 50 percent.

(3) Annual area-specific Medicare+Choice capitation rate

(A) In general

For purposes of paragraph (1)(A), subject to subparagraph (B), the annual area-specific Medicare+Choice capitation rate for a Medicare+Choice payment area--

(i) for 1998 is, subject to subparagraph (D), the annual per capita rate of payment for 1997 determined under section 1395mm(a)(1)(C) of this title for the area, increased by the national per capita Medicare+Choice growth percentage for 1998 (described in paragraph (6)(A)); or

(ii) for a subsequent year is the annual area-specific Medicare+Choice capitation rate for the previous year determined under this paragraph for the area, increased by the national per capita Medicare+Choice growth percentage for such subsequent year.

(B) Removal of medical education from calculation of adjusted average per capita cost

(i) In general

In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 1998), the annual per capita rate of payment for 1997 determined under section 1395mm(a)(1)(C) of this title shall be adjusted to exclude from the rate the applicable percent (specified in clause (ii)) of the payment adjustments described in subparagraph (C).

(ii) Applicable percent

For purposes of clause (i), the applicable percent for--

(I) 1998 is 20 percent,

(II) 1999 is 40 percent,

(III) 2000 is 60 percent,

(IV) 2001 is 80 percent, and

(V) a succeeding year is 100 percent.

(C) Payment adjustment

(i) In general

Subject to clause (ii), the payment adjustments described in this subparagraph are payment adjustments which the Secretary estimates were payable during 1997--

(I) for the indirect costs of medical education under section 1395ww(d)(5)(B) of this title, and

(II) for direct graduate medical education costs under section 1395ww(h) of this title.

(ii) Treatment of payments covered under state hospital reimbursement system

To the extent that the Secretary estimates that an annual per capita rate of payment for 1997 described in clause (i) reflects payments to hospitals reimbursed under section 1395f(b)(3) of this title, the Secretary shall estimate a payment adjustment that is comparable to the payment adjustment that would have been made under clause (i) if the hospitals had not been reimbursed under such section.

(D) Treatment of areas with highly variable payment rates

In the case of a Medicare+Choice payment area for which the annual per capita rate of payment determined under section 1395mm(a)(1)(C) of this title for 1997 varies by more than 20 percent from such rate for 1996, for purposes of this subsection the Secretary may substitute for such rate for 1997 a rate that is more representative of the costs of the enrollees in the area.

(4) Input-price-adjusted annual national Medicare+Choice capitation rate

(A) In general

For purposes of paragraph (1)(A), the input-price-adjusted annual national Medicare+Choice capitation rate for a Medicare+Choice payment area for a year is equal to the sum, for all the types of medicare services (as classified by the Secretary), of the product (for each such type of service) of--

(i) the national standardized annual Medicare+Choice capitation rate (determined under subparagraph (B)) for the year,

(ii) the proportion of such rate for the year which is attributable to such type of services, and

(iii) an index that reflects (for that year and that type of services) the relative input price of such services in the area compared to the national average input price of such services.

In applying clause (iii), the Secretary may, subject to subparagraph (C), apply those indices under this title that are used in applying (or updating) national payment rates for specific areas and localities.

(B) National standardized annual Medicare+Choice capitation rate

In subparagraph (A)(i), the "national standardized annual Medicare+Choice capitation rate" for a year is equal to--

(i) the sum (for all Medicare+Choice payment areas) of the product of--

(I) the annual area-specific Medicare+Choice capitation rate for that year for the area under paragraph (3), and

(II) the average number of medicare beneficiaries residing in that area in the year, multiplied by the average of the risk factor weights used to adjust payments under subsection (a)(1)(A) of this section for such beneficiaries in such area; divided by

(ii) the sum of the products described in clause (i)(II) for all areas for that year.

(C) Special rules for 1998

In applying this paragraph for 1998--

(i) medicare services shall be divided into 2 types of services: part A services and part B services;

(ii) the proportions described in subparagraph (A)(ii)--

(I) for part A services shall be the ratio (expressed as a percentage) of the national average annual per capita rate of payment for part A for 1997 to the total national average annual per capita rate of payment for parts A and B for 1997, and

(II) for part B services shall be 100 percent minus the ratio described in subclause (I);

(iii) for part A services, 70 percent of payments attributable to such services shall be adjusted by the index used under section 1395ww(d)(3)(E) of this title to adjust payment rates for relative hospital wage levels for hospitals located in the payment area involved;

(iv) for part B services--

(I) 66 percent of payments attributable to such services shall be adjusted by the index of the geographic area factors under section 1395w-4(e) of this title used to adjust payment rates for physicians' services furnished in the payment area, and

(II) of the remaining 34 percent of the amount of such payments, 40 percent shall be adjusted by the index described in clause (iii); and

(v) the index values shall be computed based only on the beneficiary population who are 65 years of age or older and who are not determined to have end stage renal disease.

The Secretary may continue to apply the rules described in this subparagraph (or similar rules) for 1999.

(5) Payment adjustment budget neutrality factor

For purposes of paragraph (1)(A), for each year, the Secretary shall determine a budget neutrality adjustment factor so that the aggregate of the payments under this part (other than those attributable to subsections (a)(3)(C)(iii) and (i)) shall equal the aggregate payments that would have been made under this part if payment were based entirely on area-specific capitation rates.

(6) National per capita Medicare+Choice growth percentage defined

(A) In general

In this part, the "national per capita Medicare+Choice growth percentage" for a year is the percentage determined by the Secretary, by March 1st before the beginning of the year involved, to reflect the Secretary's estimate of the projected per capita rate of growth in expenditures under this title for an individual entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter, reduced by the number of percentage points specified in subparagraph (B) for the year. Separate determinations may be made for aged enrollees, disabled enrollees, and enrollees with end- stage renal disease.

(B) Adjustment

The number of percentage points specified in this subparagraph is--(i) for 1998, 0.8 percentage points,

(ii) for 1999, 0.5 percentage points,

(iii) for 2000, 0.5 percentage points,

(iv) for 2001, 0.5 percentage points,

(v) for 2002, 0.3 percentage points, and

(vi) for a year after 2002, 0 percentage points.

(C) Adjustment for over or under projection of national per capita Medicare+Choice growth percentage

Beginning with rates calculated for 1999, before computing rates for a year as described in paragraph (1), the Secretary shall adjust all area-specific and national Medicare+Choice capitation rates (and beginning in 2000, the minimum amount) for the previous year for the differences between the projections of the national per capita Medicare+Choice growth percentage for that year and previous years and the current estimate of such percentage for such years.

(7) Adjustment for National coverage determinations and legislative changes in benefits

If the Secretary makes a determination with respect to coverage under this subchapter or there is a change in benefits required to be provided under this part that the Secretary projects will result in a significant increase in the costs to Medicare+Choice of providing benefits under contracts under this part (for periods after any period described in section 1395w-22(a)(5) of this title), the Secretary shall adjust appropriately the payments to such organizations under this part. Such projection and adjustment shall be based on an analysis by the Chief Actuary of the Health Care Financing Administration of the actuarial costs associated with the new benefits.

(d) Medicare+Choice payment area defined

(1) In general

In this part, except as provided in paragraph (3), the term "Medicare+Choice payment area" means a county, or equivalent area specified by the Secretary.

(2) Rule for ESRD beneficiaries

In the case of individuals who are determined to have end stage renal disease, the Medicare+Choice payment area shall be a State or such other payment area as the Secretary specifies.

(3) Geographic adjustment

(A) In general

Upon written request of the chief executive officer of a State for a contract year (beginning after 1998) made by not later than February 1 of the previous year, the Secretary shall make a geographic adjustment to a Medicare+Choice payment area in the State otherwise determined under paragraph (1)--

(i) to a single statewide Medicare+Choice payment area,

(ii) to the metropolitan based system described in subparagraph (C), or

(iii) to consolidating into a single Medicare+Choice payment area noncontiguous counties (or equivalent areas described in paragraph (1)) within a State.

Such adjustment shall be effective for payments for months beginning with January of the year following the year in which the request is received.

(B) Budget neutrality adjustment

In the case of a State requesting an adjustment under this paragraph, the Secretary shall initially (and annually thereafter) adjust the payment rates otherwise established under this section for Medicare+Choice payment areas in the State in a manner so that the aggregate of the payments under this section in the State shall not exceed the aggregate payments that would have been made under this section for Medicare+Choice payment areas in the State in the absence of the adjustment under this paragraph.

(C) Metropolitan based system

The metropolitan based system described in this subparagraph is one in which--

(i) all the portions of each metropolitan statistical area in the State or in the case of a consolidated metropolitan statistical area, all of the portions of each primary metropolitan statistical area within the consolidated area

within the State, are treated as a single Medicare+Choice payment area, and

(ii) all areas in the State that do not fall within a metropolitan statistical area are treated as a single Medicare+Choice payment area.

(D) Areas

In subparagraph (C), the terms "metropolitan statistical area", "consolidated metropolitan statistical area", and "primary metropolitan statistical area" mean any area designated as such by the Secretary of Commerce.

(e) Special rules for individuals electing MSA plans

(1) In general

If the amount of the Medicare+Choice monthly MSA premium (as defined in section 1395w-24(b)(2)(C) of this title) for an MSA plan for a year is less than 1/12 of the annual Medicare+Choice capitation rate applied under this section for the area and year involved, the Secretary shall deposit an amount equal to 100 percent of such difference in a Medicare+Choice MSA established (and, if applicable, designated) by the individual under paragraph (2).

(2) Establishment and designation of Medicare+Choice medical savings account as requirement for payment of contribution

In the case of an individual who has elected coverage under an MSA plan, no payment shall be made under paragraph (1) on behalf of an individual for a month unless the individual--

(A) has established before the beginning of the month (or by such other deadline as the Secretary may specify) a Medicare+Choice MSA (as defined in section 138(b)(2) of Title 26), and

(B) if the individual has established more than one such Medicare+Choice MSA, has designated one of such accounts as the individual's Medicare+Choice MSA for purposes of this part.

Under rules under this section, such an individual may change the designation of such account under subparagraph (B) for purposes of this part.

(3) Lump-sum deposit of medical savings account contribution

In the case of an individual electing an MSA plan effective beginning with a month in a year, the amount of the contribution to the Medicare+Choice MSA on behalf of the individual for that month and all successive months in the year shall be deposited during that first month. In the case of a termination of such an election as of a month before the end of a year, the Secretary shall provide for a procedure for the recovery of deposits attributable to the remaining months in the year.

(f) Payments from trust fund

The payment to a Medicare+Choice organization under this section for individuals enrolled under this part with the organization and payments to a Medicare+Choice MSA under subsection (e)(1) of this section shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines reflects the relative weight that benefits under part A and under part B of this subchapter represents of the actuarial value of the total benefits under this subchapter. Monthly payments otherwise payable under this section for October 2000 shall be paid on the first business day of such month. Monthly payments otherwise payable under this section for October 2001 shall be paid on the last business day of September 2001. Monthly payments otherwise payable under this section for October 2006 shall be paid on the first business day of October 2006.

(g) Special rule for certain inpatient hospital stays

In the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in

section 1395ww(d)(1)(B) of this title) as of the effective date of the individual's--

(1) election under this part of a Medicare+Choice plan offered by a Medicare+Choice organization--

(A) payment for such services until the date of the individual's discharge shall be made under this subchapter through the Medicare+Choice plan or the original medicare fee-for-service program option described in section 1395w-21(a)(1)(A) of this title (as the case may be) elected before the election with such organization,

(B) the elected organization shall not be financially responsible for payment for such services until the date after the date of the individual's discharge, and

(C) the organization shall nonetheless be paid the full amount otherwise payable to the organization under this part; or

(2) termination of election with respect to a Medicare+Choice organization under this part--

(A) the organization shall be financially responsible for payment for such services after such date and until the date of the individual's discharge,

(B) payment for such services during the stay shall not be made under section 1395ww(d) of this title or by any succeeding Medicare+Choice organization, and

(C) the terminated organization shall not receive any payment with respect to the individual under this part during the period the individual is not enrolled.

(h) Special rule for hospice care

(1) Information

A contract under this part shall require the Medicare+Choice organization to inform each individual enrolled under this part with a Medicare+Choice plan offered by the organization about the availability of hospice care if--

(A) a hospice program participating under this subchapter is located within the organization's service area; or

(B) it is common practice to refer patients to hospice programs outside such service area.

(2) Payment

If an individual who is enrolled with a Medicare+Choice organization under this part makes an election under section 1395d(d)(1) of this title to receive hospice care from a particular hospice program--

(A) payment for the hospice care furnished to the individual shall be made to the hospice program elected by the individual by the Secretary;

(B) payment for other services for which the individual is eligible notwithstanding the individual's election of hospice care under section 1395d(d)(1) of this title, including services not related to the individual's terminal illness, shall be made by the Secretary to the Medicare+Choice organization or the provider or supplier of the service instead of payments calculated under subsection (a); and

(C) the Secretary shall continue to make monthly payments to the Medicare+Choice organization in an amount equal to the value of the additional benefits required under section 1395w-24(f)(1)(A) of this title.

(i) New entry bonus

(1) In general

Subject to paragraphs (2) and (3), in the case of Medicare+Choice payment area in which a Medicare+Choice plan has not been offered since 1997 (or in which all organizations that offered a plan since such date have filed notice with the Secretary, as of October 13, 1999, that they will not be offering such a plan as of January 1, 2000, or filed notice with the Secretary as of October 3, 2000, that they will not be offering such a plan as of January 1, 2001), the amount of the monthly payment otherwise made under this section shall be increased--

(A) only for the first 12 months in which any Medicare+Choice plan is offered in the area, by 5 percent of

the total monthly payment otherwise computed for such payment area; and

(B) only for the subsequent 12 months, by 3 percent of the total monthly payment otherwise computed for such payment area.

(2) Period of application

Paragraph (1) shall only apply to payment for Medicare +Choice plans which are first offered in a Medicare+Choice payment area during the 2-year period beginning on January 1, 2000.

(3) Limitation to organization offering first plan in an area

Paragraph (1) shall only apply to payment to the first Medicare+Choice organization that offers a Medicare+Choice plan in each Medicare+Choice payment area, except that if more than one such organization first offers such a plan in an area on the same date, paragraph (1) shall apply to payment for such organizations.

(4) Construction

Nothing in paragraph (1) shall be construed as affecting the calculation of the annual Medicare+Choice capitation rate under subsection (c) for any payment area or as applying to payment for any period not described in such paragraph and paragraph (2).

(5) Offered defined

In this subsection, the term "offered" means, with respect to a Medicare+Choice plan as of a date, that a Medicare+Choice eligible individual may enroll with the plan on that date, regardless of when the enrollment takes effect or when the individual obtains benefits under the plan.

42 U.S.C. § 1395w-24. Premiums

(a) Submission of proposed premiums and related information

(1) In general

Not later than July 1 of each year, each Medicare+Choice organization shall submit to the Secretary, in a form and manner specified by the Secretary and for each Medicare+Choice plan for the service area (or segment of such an area if permitted under subsection (h)) in which it intends to be offered in the following year--

(A) the information described in paragraph (2), (3), or (4) for the type of plan involved; and

(B) the enrollment capacity (if any) in relation to the plan and area.

(2) Information required for coordinated care plans

For a Medicare+Choice plan described in section 1395w-21(a)(2)(A) of this title, the information described in this paragraph is as follows:

(A) Basic (and additional) benefits

For benefits described in section 1395w-22(a)(1)(A) of this title--

(i) the adjusted community rate (as defined in subsection (f)(3) of this section);

(ii) the Medicare+Choice monthly basic beneficiary premium (as defined in subsection (b)(2)(A) of this section);

(iii) a description of deductibles, coinsurance, and copayments applicable under the plan and the actuarial value of such deductibles, coinsurance, and copayments, described in subsection (e)(1)(A) of this section; and (iv) if required under subsection (f)(1) of this section, a description of the additional benefits to be provided pursuant to such subsection and the value determined for such proposed benefits under such subsection.

(B) Supplemental benefits

For benefits described in section 1395w-22(a)(3) of this title--

(i) the adjusted community rate (as defined in subsection (f)(3) of this section);

(ii) the Medicare+Choice monthly supplemental beneficiary premium (as defined in subsection (b)(2)(B) of this section); and

(iii) a description of deductibles, coinsurance, and copayments applicable under the plan and the actuarial value of such deductibles, coinsurance, and copayments, described in subsection (e)(2) of this section.

(3) Requirements for MSA plans

For an MSA plan described, the information described in this paragraph is as follows:

(A) Basic (and additional) benefits

For benefits described in section 1395w-22(a)(1)(A) of this title, the amount of the Medicare+Choice monthly MSA premium.

(B) Supplemental benefits

For benefits described in section 1395w-22(a)(3) of this title, the amount of the Medicare+Choice monthly supplementary beneficiary premium.

(4) Requirements for private fee-for-service plans

For a Medicare+Choice plan described in section 1395w-21(a)(2)(C) of this title for benefits described in section 1395w-22(a)(1)(A) of this title, the information described in this paragraph is as follows:

(A) Basic (and additional) benefits

For benefits described in section 1395w-22(a)(1)(A) of this title--

(i) the adjusted community rate (as defined in subsection (f)(3) of this section);

(ii) the amount of the Medicare+Choice monthly basic beneficiary premium;

(iii) a description of the deductibles, coinsurance, and copayments applicable under the plan, and the actuarial value of such deductibles, coinsurance, and copayments, as described in subsection (e)(4)(A) of this section; and

(iv) if required under subsection (f)(1) of this section, a description of the additional benefits to be provided pursuant to such subsection and the value determined for such proposed benefits under such subsection.

(B) Supplemental benefits

For benefits described in section 1395w-22(a)(3) of this title, the amount of the Medicare+Choice monthly supplemental beneficiary premium (as defined in subsection (b)(2)(B) of this section).

(5) Review

(A) In general

Subject to subparagraph (B), the Secretary shall review the adjusted community rates, the amounts of the basic and supplemental premiums, and values filed under this subsection and shall approve or disapprove such rates, amounts, and values so submitted. The Chief Actuary of the Health Care Financing Administration shall review the actuarial assumptions and data used by the Medicare+Choice organization with respect to such rates, amounts, and values so submitted to determine the appropriateness of such assumptions and data.

(B) Exception

The Secretary shall not review, approve, or disapprove the amounts submitted under paragraph (3) or subparagraphs (A)(ii) and (B) of paragraph (4).

(b) Monthly premium charged

(1) In general

(A) Rule for other than MSA plans

The monthly amount of the premium charged to an individual enrolled in a Medicare+Choice plan (other than an MSA plan) offered by a Medicare+Choice organization shall

be equal to the sum of the Medicare+Choice monthly basic beneficiary premium and the Medicare+Choice monthly supplementary beneficiary premium (if any).

(B) MSA plans

The monthly amount of the premium charged to an individual enrolled in an MSA plan offered by a Medicare+Choice organization shall be equal to the Medicare+Choice monthly supplemental beneficiary premium (if any).

(2) Premium terminology defined

For purposes of this part:

(A) The Medicare+Choice monthly basic beneficiary premium

The term "Medicare+Choice monthly basic beneficiary premium" means, with respect to a Medicare+Choice plan, the amount authorized to be charged under subsection (e)(1) of this section for the plan, or, in the case of a Medicare+Choice private fee-for-service plan, the amount filed under subsection (a)(4)(A)(ii) of this section.

(B) Medicare+Choice monthly supplemental beneficiary premium

The term "Medicare+Choice monthly supplemental beneficiary premium" means, with respect to a Medicare+Choice plan, the amount authorized to be charged under subsection (e)(2) of this section for the plan or, in the case of a MSA plan or Medicare+Choice private fee-for-service plan, the amount filed under paragraph (3)(B) or (4)(B) of subsection (a) of this section.

(C) Medicare+Choice monthly MSA premium

The term "Medicare+Choice monthly MSA premium" means, with respect to a Medicare+Choice plan, the amount of such premium filed under subsection (a)(3)(A) of this section for the plan.

(c) Uniform premium

The Medicare+Choice monthly basic and supplemental beneficiary premium, the Medicare+Choice monthly MSA premium charged under subsection (b) of this section of a Medicare+Choice organization under this part may not vary among individuals enrolled in the plan.

(d) Terms and conditions of imposing premiums

Each Medicare+Choice organization shall permit the payment of Medicare+Choice monthly basic and supplemental beneficiary premiums on a monthly basis, may terminate election of individuals for a Medicare+Choice plan for failure to make premium payments only in accordance with section 1395w-21(g)(3)(B)(i) of this title, and may not provide for cash or other monetary rebates as an inducement for enrollment or otherwise.

(e) Limitation on enrollee liability

(1) For basic and additional benefits

In no event may--

(A) the Medicare+Choice monthly basic beneficiary premium (multiplied by 12) and the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled under this part with a Medicare+Choice plan described in section 1395w-21(a)(2)(A) of this title of an organization with respect to required benefits described in section 1395w- 22(a)(1)(A) of this title and additional benefits (if any) required under subsection (f)(1)(A) of this section for a year, exceed

(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter if they were not members of a Medicare+Choice organization for the year.

(2) For supplemental benefits

If the Medicare+Choice organization provides to its members enrolled under this part in a Medicare+Choice plan described in section 1395w-21(a)(2)(A) of this title with

respect to supplemental benefits described in section 1395w-22(a)(3) of this title, the sum of the Medicare+Choice monthly supplemental beneficiary premium (multiplied by 12) charged and the actuarial value of its deductibles, coinsurance, and copayments charged with respect to such benefits may not exceed the adjusted community rate for such benefits (as defined in subsection (f)(3) of this section).

(3) Determination on other basis

If the Secretary determines that adequate data are not available to determine the actuarial value under paragraph (1)(A) or (2), the Secretary may determine such amount with respect to all individuals in same geographic area, the State, or in the United States, eligible to enroll in the Medicare+Choice plan involved under this part or on the basis of other appropriate data.

(4) Special rule for private fee-for-service plans

With respect to a Medicare+Choice private fee-for-service plan (other than a plan that is an MSA plan), in no event may--

(A) the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled under this part with such a plan of an organization with respect to required benefits described in section 1395w-22(a)(1) of this title, exceed

(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter if they were not members of a Medicare+Choice organization for the year.

(f) Requirement for additional benefits

(1) Requirement

(A) In general

Each Medicare+Choice organization (in relation to a Medicare+Choice plan, other than an MSA plan, it offers) shall provide that if there is an excess amount (as defined in

subparagraph (B)) for the plan for a contract year, subject to the succeeding provisions of this subsection, the organization shall provide to individuals such additional benefits (as the organization may specify) in a value which the Secretary determines is at least equal to the adjusted excess amount (as defined in subparagraph (C)).

(B) Excess amount

For purposes of this paragraph, the "excess amount", for an organization for a plan, is the amount (if any) by which-- -

(i) the average of the capitation payments made to the organization under section 1395w-23 of this title for the plan at the beginning of contract year, exceeds

(ii) the actuarial value of the required benefits described in section 1395w-22(a)(1)(A) of this title under the plan for individuals under this part, as determined based upon an adjusted community rate described in paragraph (3) (as reduced for the actuarial value of the coinsurance, copayments, and deductibles under parts A and B of this subchapter).

(C) Adjusted excess amount

For purposes of this paragraph, the "adjusted excess amount", for an organization for a plan, is the excess amount reduced to reflect any amount withheld and reserved for the organization for the year under paragraph (2).

(D) Uniform application

This paragraph shall be applied uniformly for all enrollees for a plan.

(E) Construction

Nothing in this subsection shall be construed as preventing a Medicare+Choice organization from providing supplemental benefits (described in section 1395w-22(a)(3) of this title) that are in addition to the health care benefits otherwise required to be provided under this paragraph and from imposing a premium for such supplemental benefits.

(2) Stabilization fund

A Medicare +Choice organization may provide that a part of the value of an excess amount described in paragraph (1) be withheld and reserved in the Federal Hospital Insurance Trust Fund and in the Federal Supplementary Medical Insurance Trust Fund (in such proportions as the Secretary determines to be appropriate) by the Secretary for subsequent annual contract periods, to the extent required to stabilize and prevent undue fluctuations in the additional benefits offered in those subsequent periods by the organization in accordance with such paragraph. Any of such value of the amount reserved which is not provided as additional benefits described in paragraph (1)(A) to individuals electing the Medicare+Choice plan of the organization in accordance with such paragraph prior to the end of such periods, shall revert for the use of such trust funds.

(3) Adjusted community rate

For purposes of this subsection, subject to paragraph (4), the term "adjusted community rate" for a service or services means, at the election of a Medicare+Choice organization, either--

(A) the rate of payment for that service or services which the Secretary annually determines would apply to an individual electing a Medicare+Choice plan under this part if the rate of payment were determined under a "community rating system" (as defined in section 300e-1(8) of this title, other than subparagraph (C)), or

(B) such portion of the weighted aggregate premium, which the Secretary annually estimates would apply to such an individual, as the Secretary annually estimates is attributable to that service or services, but adjusted for differences between the utilization characteristics of the individuals electing coverage under this part and the utilization characteristics of the other enrollees with the plan (or, if the Secretary finds that adequate data are not available to adjust for those differences, the differences between the

utilization characteristics of individuals selecting other Medicare+Choice coverage, or Medicare+Choice eligible individuals in the area, in the State, or in the United States, eligible to elect Medicare+Choice coverage under this part and the utilization characteristics of the rest of the population in the area, in the State, or in the United States, respectively).

(4) Determination based on insufficient data

For purposes of this subsection, if the Secretary finds that there is insufficient enrollment experience to determine an average of the capitation payments to be made under this part at the beginning of a contract period or to determine (in the case of a newly operated provider-sponsored organization or other new organization) the adjusted community rate for the organization, the Secretary may determine such an average based on the enrollment experience of other contracts entered into under this part and may determine such a rate using data in the general commercial marketplace.

(g) Prohibition of State imposition of premium taxes

No State may impose a premium tax or similar tax with respect to payments to Medicare+Choice organizations under section 1395w-23 of this title.

(h) Permitting use of segments of service areas

The Secretary shall permit a Medicare+Choice organization to elect to apply the provisions of this section uniformly to separate segments of a service area (rather than uniformly to an entire service area) as long as such segments are composed of one or more Medicare+Choice payment areas.

42 U.S.C. § 1395w-25. Organizational and financial requirements for Medicare+Choice organizations; provider-sponsored organizations

(a) Organized and licensed under state law

(1) In general

Subject to paragraphs (2) and (3), a Medicare + Choice organization shall be organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers a Medicare + Choice plan.

(2) Special exception for provider-sponsored organizations

(A) In general

In the case of a provider-sponsored organization that seeks to offer a Medicare + Choice plan in a State, the Secretary shall waive the requirement of paragraph (1) that the organization be licensed in that State if--

(i) the organization files an application for such waiver with the Secretary by not later than November 1, 2002, and

(ii) the Secretary determines, based on the application and other evidence presented to the Secretary, that any of the grounds for approval of the application described in subparagraph (B), (C), or (D) has been met.

(B) Failure to act on licensure application on a timely basis

The ground for approval of such a waiver application described in this subparagraph is that the State has failed to complete action on a licensing application of the organization within 90 days of the date of the State's receipt of a substantially complete application. No period before the date of the enactment of this section shall be included in determining such 90-day period.

(C) Denial of application based on discriminatory treatment

The ground for approval of such a waiver application described in this subparagraph is that the State has denied such a licensing application and--

(i) the standards or review process imposed by the State as a condition of approval of the license imposes any material requirements, procedures, or standards (other than solvency requirements) to such organizations that are not generally applicable to other entities engaged in a substantially similar business, or

(ii) the State requires the organization, as a condition of licensure, to offer any product or plan other than a Medicare + Choice plan.

(D) Denial of application based on application of solvency requirements

With respect to waiver applications filed on or after the date of publication of solvency standards under section 1395w-26(a) of this title, the ground for approval of such a waiver application described in this subparagraph is that the State has denied such a licensing application based (in whole or in part) on the organization's failure to meet applicable solvency requirements and--

(i) such requirements are not the same as the solvency standards established under section 1395w-26(a) of this title; or

(ii) the State has imposed as a condition of approval of the license documentation or information requirements relating to solvency or other material requirements, procedures, or standards relating to solvency that are different from the requirements, procedures, and standards applied by the Secretary under subsection (d)(2) of this section.

For purposes of this paragraph, the term "solvency requirements" means requirements relating to solvency and other matters covered under the standards established under section 1395w-26(a) of this title.

(E) Treatment of waiver

In the case of a waiver granted under this paragraph for a provider-sponsored organization with respect to a State--

(i) Limitation to state

The waiver shall be effective only with respect to that State and does not apply to any other State.

(ii) Limitation to 36-month period

The waiver shall be effective only for a 36-month period and may not be renewed.

(iii) Conditioned on compliance with consumer protection and quality standards

The continuation of the waiver is conditioned upon the organization's compliance with the requirements described in subparagraph (G).

(iv) Preemption of state law

Any provisions of law of that State which relate to the licensing of the organization and which prohibit the organization from providing coverage pursuant to a contract under this part shall be superseded.

(F) Prompt action on application

The Secretary shall grant or deny such a waiver application within 60 days after the date the Secretary determines that a substantially complete waiver application has been filed. Nothing in this section shall be construed as preventing an organization which has had such a waiver application denied from submitting a subsequent waiver application.

(G) Application and enforcement of state consumer protection and quality standards

(i) In general

A waiver granted under this paragraph to an organization with respect to licensing under State law is conditioned upon the organization's compliance with all consumer protection and quality standards insofar as such standards--

(I) would apply in the State to the organization if it were licensed under State law;

(II) are generally applicable to other Medicare + Choice organizations and plans in the State; and

(III) are consistent with the standards established under this part.

Such standards shall not include any standard preempted under section 1395w-26(b)(3)(B) of this title.

(ii) Incorporation into contract

In the case of such a waiver granted to an organization with respect to a State, the Secretary shall incorporate the requirement that the organization (and Medicare + Choice plans it offers) comply with standards under clause (i) as part of the contract between the Secretary and the organization under section 1395w-27 of this title.

(iii) Enforcement

In the case of such a waiver granted to an organization with respect to a State, the Secretary may enter into an agreement with the State under which the State agrees to provide for monitoring and enforcement activities with respect to compliance of such an organization and its Medicare + Choice plans with such standards. Such monitoring and enforcement shall be conducted by the State in the same manner as the State enforces such standards with respect to other Medicare + Choice organizations and plans, without discrimination based on the type of organization to which the standards apply. Such an agreement shall specify or establish mechanisms by which compliance activities are undertaken, while not lengthening the time required to review and process applications for waivers under this paragraph.

(H) Report

By not later than December 31, 2001, the Secretary shall submit to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate a report regarding whether the waiver process under this paragraph should be continued after December 31, 2002. In making

such recommendation, the Secretary shall consider, among other factors, the impact of such process on beneficiaries and on the long-term solvency of the program under this title.

(3) Licensure does not substitute for or constitute certification

The fact that an organization is licensed in accordance with paragraph (1) does not deem the organization to meet other requirements imposed under this part.

(b) Assumption of full financial risk

The Medicare + Choice organization shall assume full financial risk on a prospective basis for the provision of the health care services for which benefits are required to be provided under section 1395w-22(a)(1) of this title, except that the organization--

(1) may obtain insurance or make other arrangements for the cost of providing to any enrolled member such services the aggregate value of which exceeds such aggregate level as the Secretary specifies from time to time,

(2) may obtain insurance or make other arrangements for the cost of such services provided to its enrolled members other than through the organization because medical necessity required their provision before they could be secured through the organization,

(3) may obtain insurance or make other arrangements for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 115 percent of its income for such fiscal year, and

(4) may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions.

(c) Certification of provision against risk of insolvency for unlicensed PSOs

(1) In general

Each Medicare + Choice organization that is a provider-sponsored organization, that is not licensed by a State under subsection (a) of this section, and for which a waiver application has been approved under subsection (a)(2) of this section, shall meet standards established under section 1395w-26(a) of this title relating to the financial solvency and capital adequacy of the organization.

(2) Certification process for solvency standards for PSOs

The Secretary shall establish a process for the receipt and approval of applications of a provider-sponsored organization described in paragraph (1) for certification (and periodic recertification) of the organization as meeting such solvency standards. Under such process, the Secretary shall act upon such a certification application not later than 60 days after the date the application has been received.

(d) Provider-sponsored organization defined

(1) In general

In this part, the term "provider-sponsored organization" means a public or private entity--

(A) that is established or organized, and operated, by a health care provider, or group of affiliated health care providers,

(B) that provides a substantial proportion (as defined by the Secretary in accordance with paragraph (2)) of the health care items and services under the contract under this part directly through the provider or affiliated group of providers, and

(C) with respect to which the affiliated providers share, directly or indirectly, substantial financial risk with respect to the provision of such items and services and have at least a majority financial interest in the entity.

(2) Substantial proportion

In defining what is a "substantial proportion" for purposes of paragraph (1)(B), the Secretary--

(A) shall take into account the need for such an organization to assume responsibility for providing--

(i) significantly more than the majority of the items and services under the contract under this section through its own affiliated providers; and

(ii) most of the remainder of the items and services under the contract through providers with which the organization has an agreement to provide such items and services, in order to assure financial stability and to address the practical considerations involved in integrating the delivery of a wide range of service providers;

(B) shall take into account the need for such an organization to provide a limited proportion of the items and services under the contract through providers that are neither affiliated with nor have an agreement with the organization; and

(C) may allow for variation in the definition of substantial proportion among such organizations based on relevant differences among the organizations, such as their location in an urban or rural area.

(3) Affiliation

For purposes of this subsection, a provider is "affiliated" with another provider if, through contract, ownership, or otherwise--

(A) one provider, directly or indirectly, controls, is controlled by, or is under common control with the other,

(B) both providers are part of a controlled group of corporations under section 1563 of Title 26,

(C) each provider is a participant in a lawful combination under which each provider shares substantial financial risk in connection with the organization's operations, or

(D) both providers are part of an affiliated service group under section 414 of Title 26.

(4) Control

For purposes of paragraph (3), control is presumed to exist if one party, directly or indirectly, owns, controls, or holds the power to vote, or proxies for, not less than 51 percent of the voting rights or governance rights of another.

(5) Health care provider defined

In this subsection, the term "health care provider" means--

(A) any individual who is engaged in the delivery of health care services in a State and who is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State, and

(B) any entity that is engaged in the delivery of health care services in a State and that, if it is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State, is so licensed.

(6) Regulations

The Secretary shall issue regulations to carry out this subsection.

42 U.S.C. § 1395w-26. Establishment of standards

(a) Establishment of solvency standards for provider-sponsored organizations

(1) Establishment

(A) In general

The Secretary shall establish, on an expedited basis and using a negotiated rulemaking process under subchapter III of chapter 5 of Title 5 [5 U.S.C.A. § 561 et seq.], standards described in section 1855(c)(1) (relating to the financial solvency and capital adequacy of the organization) that entities must meet to qualify as provider-sponsored organizations under this part.

(B) Factors to consider for solvency standards

In establishing solvency standards under subparagraph (A) for provider-sponsored organizations, the Secretary shall consult with interested parties and shall take into account--

(i) the delivery system assets of such an organization and ability of such an organization to provide services directly to enrollees through affiliated providers,

(ii) alternative means of protecting against insolvency, including reinsurance, unrestricted surplus, letters of credit, guarantees, organizational insurance coverage, partnerships with other licensed entities, and valuation attributable to the ability of such an organization to meet its service obligations through direct delivery of care, and

(iii) any standards developed by the National Association of Insurance Commissioners specifically for risk-based health care delivery organizations.

(C) Enrollee protection against insolvency

Such standards shall include provisions to prevent enrollees from being held liable to any person or entity for the Medicare+Choice organization's debts in the event of the organization's insolvency.

(2) Publication of notice

In carrying out the rule-making process under this subsection, the Secretary, after consultation with the National Association of Insurance Commissioners, the American Academy of Actuaries, organizations representative of medicare beneficiaries, and other interested parties, shall publish the notice provided for under section 564(a) of Title 5, by not later than 45 days after August 5, 1997.

(3) Target date for publication of rule

As part of the notice under paragraph (2), and for purposes of this subsection, the "target date for publication" (referred to in section 564(a)(5) of such title [5 U.S.C.A. § 564(a)(5)]) shall be April 1, 1998.

(4) Abbreviated period for submission of comments

In applying section 564(c) of such title [5 U.S.C.A. § 564(c)] under this subsection, "15 days" shall be substituted for "30 days".

(5) Appointment of negotiated rulemaking committee and facilitator

The Secretary shall provide for--

(A) the appointment of a negotiated rulemaking committee under section 565(a) of such title [5 U.S.C.A. § 565(a)] by not later than 30 days after the end of the comment period provided for under section 564(c) of such title [5 U.S.C.A. § 564(c)] (as shortened under paragraph (4)), and

(B) the nomination of a facilitator under section 566(c) of such title [5 U.S.C.A. § 566(c)] by not later than 10 days after the date of appointment of the committee.

(6) Preliminary committee report

The negotiated rulemaking committee appointed under paragraph (5) shall report to the Secretary, by not later than January 1, 1998, regarding the committee's progress on achieving a consensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before 1 month before the target date for publication of the rule. If the committee reports that the committee has failed to

make significant progress towards such consensus or is unlikely to reach such consensus by the target date, the Secretary may terminate such process and provide for the publication of a rule under this subsection through such other methods as the Secretary may provide.

(7) Final committee report

If the committee is not terminated under paragraph (6), the rulemaking committee shall submit a report containing a proposed rule by not later than 1 month before the target date of publication.

(8) Interim, final effect

The Secretary shall publish a rule under this subsection in the Federal Register by not later than the target date of publication. Such rule shall be effective and final immediately on an interim basis, but is subject to change and revision after public notice and opportunity for a period (of not less than 60 days) for public comment. In connection with such rule, the Secretary shall specify the process for the timely review and approval of applications of entities to be certified as provider-sponsored organizations pursuant to such rules and consistent with this subsection.

(9) Publication of rule after public comment

The Secretary shall provide for consideration of such comments and republication of such rule by not later than 1 year after the target date of publication.

(b) Establishment of other standards

(1) In general

The Secretary shall establish by regulation other standards (not described in subsection (a)) for Medicare+Choice organizations and plans consistent with, and to carry out, this part. The Secretary shall publish such regulations by June 1, 1998. In order to carry out this requirement in a timely manner, the Secretary may promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment.

(2) Use of current standards

Consistent with the requirements of this part, standards established under this subsection shall be based on standards established under section 1876 to carry out analogous provisions of such section.

(3) Relation to State laws

(A) In general

The standards established under this subsection shall supersede any State law or regulation (including standards described in subparagraph (B)) with respect to Medicare+Choice plans which are offered by Medicare+Choice organizations under this part to the extent such law or regulation is inconsistent with such standards.

(B) Standards specifically superseded

State standards relating to the following are superseded under this paragraph:

(i) Benefit requirements (including cost-sharing requirements).

(ii) Requirements relating to inclusion or treatment of providers.

(iii) Coverage determinations (including related appeals and grievance processes).

(iv) Requirements relating to marketing materials and summaries and schedules of benefits regarding a Medicare+Choice plan.

(4) Prohibition of midyear implementation of significant new regulatory requirements

The Secretary may not implement, other than at the beginning of a calendar year, regulations under this section that impose new, significant regulatory requirements on a Medicare+Choice organization or plan.

42 U.S.C. § 1395w-27. Contracts with Medicare+Choice organizations

(a) In general

The Secretary shall not permit the election under section 1395w-21 of this title of a Medicare+Choice plan offered by a Medicare+Choice organization under this part, and no payment shall be made under section 1395w-23 of this title to an organization, unless the Secretary has entered into a contract under this section with the organization with respect to the offering of such plan. Such a contract with an organization may cover more than 1 Medicare+Choice plan. Such contract shall provide that the organization agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

(b) Minimum enrollment requirements

(1) In general

Subject to paragraph (2), the Secretary may not enter into a contract under this section with a Medicare+Choice organization unless the organization has--

(A) at least 5,000 individuals (or 1,500 individuals in the case of an organization that is a provider-sponsored organization) who are receiving health benefits through the organization, or

(B) at least 1,500 individuals (or 500 individuals in the case of an organization that is a provider-sponsored organization) who are receiving health benefits through the organization if the organization primarily serves individuals residing outside of urbanized areas.

(2) Application to MSA plans

In applying paragraph (1) in the case of a Medicare+Choice organization that is offering an MSA plan, paragraph (1) shall be applied by substituting covered lives for individuals.

(3) Allowing transition

The Secretary may waive the requirement of paragraph (1) during the first 3 contract years with respect to an organization.

(c) Contract period and effectiveness

(1) Period

Each contract under this section shall be for a term of at least 1 year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term.

(2) Termination authority

In accordance with procedures established under subsection (h) of this section, the Secretary may at any time terminate any such contract if the Secretary determines that the organization--

(A) has failed substantially to carry out the contract;

(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this part; or

(C) no longer substantially meets the applicable conditions of this part.

(3) Effective date of contracts

The effective date of any contract executed pursuant to this section shall be specified in the contract, except that in no case shall a contract under this section which provides for coverage under an MSA plan be effective before January 1999 with respect to such coverage.

(4) Previous terminations

(A) In general

The Secretary may not enter into a contract with a Medicare+Choice organization if a previous contract with that organization under this section was terminated at the request of the organization within the preceding 2-year period, except as provided in subparagraph (B) and except in such other circumstances which warrant special consideration, as determined by the Secretary.

(B) Earlier re-entry permitted where change in payment policy

Subparagraph (A) shall not apply with respect to the offering by a Medicare+Choice organization of a Medicare +Choice plan in a Medicare+Choice payment area if during the 6-month period beginning on the date the organization notified the Secretary of the intention to terminate the most recent previous contract, there was a legislative change enacted (or a regulatory change adopted) that has the effect of increasing payment amounts under section 1395w-23 of this title for that Medicare+Choice payment area.

(5) Contracting authority

The authority vested in the Secretary by this part may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this title.

(d) Protections against fraud and beneficiary protections

(1) Periodic auditing

The Secretary shall provide for the annual auditing of the financial records (including data relating to medicare utilization, costs, and computation of the adjusted community rate) of at least one-third of the Medicare+Choice organizations offering Medicare+Choice plans under this part. The Comptroller General shall monitor auditing activities conducted under this subsection.

(2) Inspection and audit

Each contract under this section shall provide that the Secretary, or any person or organization designated by the Secretary--

(A) shall have the right to inspect or otherwise evaluate (i) the quality, appropriateness, and timeliness of services performed under the contract, and (ii) the facilities of the

organization when there is reasonable evidence of some need for such inspection, and

(B) shall have the right to audit and inspect any books and records of the Medicare+Choice organization that pertain (i) to the ability of the organization to bear the risk of potential financial losses, or (ii) to services performed or determinations of amounts payable under the contract.

(3) Enrollee notice at time of termination

Each contract under this section shall require the organization to provide (and pay for) written notice in advance of the contract's termination, as well as a description of alternatives for obtaining benefits under this title, to each individual enrolled with the organization under this part.

(4) Disclosure

(A) In general

Each Medicare+Choice organization shall, in accordance with regulations of the Secretary, report to the Secretary financial information which shall include the following:

(i) Such information as the Secretary may require demonstrating that the organization has a fiscally sound operation.

(ii) A copy of the report, if any, filed with the Health Care Financing Administration containing the information required to be reported under section 1320a-3 of this title by disclosing entities.

(iii) A description of transactions, as specified by the Secretary, between the organization and a party in interest. Such transactions shall include--

(I) any sale or exchange, or leasing of any property between the organization and a party in interest;

(II) any furnishing for consideration of goods, services (including management services), or facilities between the organization and a party in interest, but not including salaries paid to employees for services provided in the normal course of their employment and health services provided to members

by hospitals and other providers and by staff, medical group (or groups), individual practice association (or associations), or any combination thereof; and

(III) any lending of money or other extension of credit between an organization and a party in interest.

The Secretary may require that information reported respecting an organization which controls, is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the organization and such entity.

(B) Party in interest defined

For the purposes of this paragraph, the term "party in interest" means--

(i) any director, officer, partner, or employee responsible for management or administration of a Medicare+Choice organization, any person who is directly or indirectly the beneficial owner of more than 5 percent of the equity of the organization, any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than 5 percent of the organization, and, in the case of a Medicare+Choice organization organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;

(ii) any entity in which a person described in clause (i)--

(I) is an officer or director;

(II) is a partner (if such entity is organized as a partnership);

(III) has directly or indirectly a beneficial interest of more than 5 percent of the equity; or

(IV) has a mortgage, deed of trust, note, or other interest valuing more than 5 percent of the assets of such entity;

(iii) any person directly or indirectly controlling, controlled by, or under common control with an organization; and

(iv) any spouse, child, or parent of an individual described in clause (i).

(C) Access to information

Each Medicare+Choice organization shall make the information reported pursuant to subparagraph (A) available to its enrollees upon reasonable request.

(5) Loan information

The contract shall require the organization to notify the Secretary of loans and other special financial arrangements which are made between the organization and subcontractors, affiliates, and related parties.

(e) Additional contract terms

(1) In general

The contract shall contain such other terms and conditions not inconsistent with this part (including requiring the organization to provide the Secretary with such information) as the Secretary may find necessary and appropriate.

(2) Cost-sharing in enrollment-related costs

(A) In general

A Medicare+Choice organization shall pay the fee established by the Secretary under subparagraph (B).

(B) Authorization

The Secretary is authorized to charge a fee to each Medicare+Choice organization with a contract under this part that is equal to the organization's pro rata share (as determined by the Secretary) of the aggregate amount of fees which the Secretary is directed to collect in a fiscal year. Any amounts collected shall be available without further appropriation to the Secretary for the purpose of carrying out section 1395w- 21 of this title (relating to enrollment and dissemination of information) and section 1395b-4 of this title (relating to the health insurance counseling and assistance program).

(C) Authorization of appropriations

There are authorized to be appropriated for the purposes described in subparagraph (B) for each fiscal year beginning with fiscal year 2001 an amount equal to $100,000,000, reduced by the amount of fees authorized to be collected under this paragraph for the fiscal year.

(D) Limitation

In any fiscal year the fees collected by the Secretary under subparagraph (B) shall not exceed the lesser of--

(i) the estimated costs to be incurred by the Secretary in the fiscal year in carrying out the activities described in section 1395w-21 of this title and section 1395b-4 of this title; or

(ii)(I) $200,000,000 in fiscal year 1998;

(II) $150,000,000 in fiscal year 1999;

(III) $100,000,000 in fiscal year 2000; and

(IV) the Medicare+Choice portion (as defined in subparagraph (E)) of $100,000,000 in fiscal year 2001 and each succeeding fiscal year.

(E) Medicare+Choice portion defined

In this paragraph, the term "Medicare +Choice portion" means, for a fiscal year, the ratio, as estimated by the Secretary, of--

(i) the average number of individuals enrolled in Medicare+Choice plans during the fiscal year, to

(ii) the average number of individuals entitled to benefits under part A of this subchapter, and enrolled under part B of this subchapter, during the fiscal year.

(f) Prompt payment by Medicare+Choice organization

(1) Requirement

A contract under this part shall require a Medicare+Choice organization to provide prompt payment (consistent with the provisions of sections 1395h and 1395u of this title) of claims submitted for services and supplies furnished to enrollees pursuant to the contract, if the services or supplies are not furnished under a contract between the organization and the

provider or supplier (or in the case of a Medicare+Choice private fee-for-service plan, if a claim is submitted to such organization by an enrollee).

(2) Secretary's option to bypass noncomplying organization

In the case of a Medicare+Choice eligible organization which the Secretary determines, after notice and opportunity for a hearing, has failed to make payments of amounts in compliance with paragraph (1), the Secretary may provide for direct payment of the amounts owed to providers and suppliers (or, in the case of a Medicare+Choice private fee-for-service plan, amounts owed to the enrollees) for covered services and supplies furnished to individuals enrolled under this part under the contract. If the Secretary provides for the direct payments, the Secretary shall provide for an appropriate reduction in the amount of payments otherwise made to the organization under this part to reflect the amount of the Secretary's payments (and the Secretary's costs in making the payments).

(g) Intermediate sanctions

(1) In general

If the Secretary determines that a Medicare+Choice organization with a contract under this section--

(A) fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

(B) imposes premiums on individuals enrolled under this part in excess of the amount of the Medicare+Choice monthly basic and supplemental beneficiary premiums permitted under section 1395w-24 of this title;

(C) acts to expel or to refuse to re-enroll an individual in violation of the provisions of this part;

(D) engages in any practice that would reasonably be expected to have the effect of denying or discouraging

enrollment (except as permitted by this part) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services;

(E) misrepresents or falsifies information that is furnished--

(i) to the Secretary under this part, or

(ii) to an individual or to any other entity under this part;

(F) fails to comply with the applicable requirements of section 1395w- 22(j)(3) or 1395w-22(k)(2)(A)(ii) of this title; or

(G) employs or contracts with any individual or entity that is excluded from participation under this subchapter under section 1320a-7 or 1320a-7a of this title for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services; the Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2).

(2) Remedies

The remedies described in this paragraph are--

(A) civil money penalties of not more than $25,000 for each determination under paragraph (1) or, with respect to a determination under subparagraph (D) or (E)(i) of such paragraph, of not more than $100,000 for each such determination, plus, with respect to a determination under paragraph (1)(B), double the excess amount charged in violation of such paragraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under paragraph (1)(D), $15,000 for each individual not enrolled as a result of the practice involved,

(B) suspension of enrollment of individuals under this part after the date the Secretary notifies the organization of a

determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur, or

(C) suspension of payment to the organization under this part for individuals enrolled after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

(3) Other intermediate sanctions

In the case of a Medicare+Choice organization for which the Secretary makes a determination under subsection (c)(2) of this section the basis of which is not described in paragraph (1), the Secretary may apply the following intermediate sanctions:

(A) Civil money penalties of not more than $25,000 for each determination under subsection (c)(2) of this section if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract.

(B) Civil money penalties of not more than $10,000 for each week beginning after the initiation of civil money penalty procedures by the Secretary during which the deficiency that is the basis of a determination under subsection (c)(2) of this section exists.

(C) Suspension of enrollment of individuals under this part after the date the Secretary notifies the organization of a determination under subsection (c)(2) of this section and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.

(D) Civil monetary penalties of not more than $100,000, or such higher amount as the Secretary may establish by regulation, where the finding under subsection (c)(2)(A) is based on the organization's termination of its contract under

this section other than at a time and in a manner provided for under subsection (a).

(4) Civil money penalties

The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under paragraph (2) or (3) in the same manner as they apply to a civil money penalty or proceeding under section 1320a-7a(a) of this title.

(h) Procedures for termination

(1) In general

The Secretary may terminate a contract with a Medicare+Choice organization under this section in accordance with formal investigation and compliance procedures established by the Secretary under which--

(A) the Secretary provides the organization with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under subsection (c)(2); and

(B) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before terminating the contract.

(2) Exception for imminent and serious risk to health

Paragraph (1) shall not apply if the Secretary determines that a delay in termination, resulting from compliance with the procedures specified in such paragraph prior to termination, would pose an imminent and serious risk to the health of individuals enrolled under this part with the organization.

(i) Medicare+Choice program compatibility with employer or union group health plans

To facilitate the offering of Medicare+Choice plans under contracts between Medicare+Choice organizations and employers, labor organizations, or the trustees of a fund established by one or more employers or labor organizations (or combination thereof) to furnish benefits to the entity's

employees, former employees (or combination thereof) or members or former members (or combination thereof) of the labor organizations, the Secretary may waive or modify requirements that hinder the design of, the offering of, or the enrollment in such Medicare+Choice plans.

42 U.S.C. § 1395w-28. Definitions; miscellaneous provisions

(a) Definitions relating to Medicare + Choice organizations
In this part--

(1) Medicare + Choice organization

The term "Medicare + Choice organization" means a public or private entity that is certified under section 1395w-26 of this title as meeting the requirements and standards of this part for such an organization.

(2) Provider-sponsored organization

The term "provider-sponsored organization" is defined in section 1395w- 25(d)(1) of this title.

(b) Definitions relating to Medicare + Choice plans

(1) Medicare + Choice plan

The term "Medicare + Choice plan" means health benefits coverage offered under a policy, contract, or plan by a Medicare + Choice organization pursuant to and in accordance with a contract under section 1395w-27 of this title.

(2) Medicare + Choice private fee-for-service plan

The term "Medicare + Choice private fee-for-service plan" means a Medicare + Choice plan that--

(A) reimburses hospitals, physicians, and other providers at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk;

(B) does not vary such rates for such a provider based on utilization relating to such provider; and

(C) does not restrict the selection of providers among those who are lawfully authorized to provide the covered services and agree to accept the terms and conditions of payment established by the plan.

(3) MSA plan

(A) In general

The term "MSA plan" means a Medicare +Choice plan that--

(i) provides reimbursement for at least the items and services described in section 1395w-22(a)(1) of this title in a year but only after the enrollee incurs countable expenses (as specified under the plan) equal to the amount of an annual deductible (described in subparagraph (B));

(ii) counts as such expenses (for purposes of such deductible) at least all amounts that would have been payable under parts A and B of this subchapter, and that would have been payable by the enrollee as deductibles, coinsurance, or copayments, if the enrollee had elected to receive benefits through the provisions of such parts; and

(iii) provides, after such deductible is met for a year and for all subsequent expenses for items and services referred to in clause (i) in the year, for a level of reimbursement that is not less than--

(I) 100 percent of such expenses, or

(II) 100 percent of the amounts that would have been paid (without regard to any deductibles or coinsurance) under parts A and B of this subchapter with respect to such expenses, whichever is less.

(B) Deductible

The amount of annual deductible under an MSA plan--

(i) for contract year 1999 shall be not more than $6,000; and

(ii) for a subsequent contract year shall be not more than the maximum amount of such deductible for the previous contract year under this subparagraph increased by the national per capita Medicare+Choice growth percentage under section 1395w-23(c)(6) of this title for the year.

If the amount of the deductible under clause (ii) is not a multiple of $50, the amount shall be rounded to the nearest multiple of $50.

(c) Other references to other terms

(1) Medicare+Choice eligible individual

The term "Medicare+Choice eligible individual" is defined in section 1395w- 21(a)(3) of this title.

(2) Medicare+Choice payment area

The term "Medicare +Choice payment area" is defined in section 1395w-23(d) of this title.

(3) National per capita Medicare+Choice growth percentage

The "national per capita Medicare+Choice growth percentage" is defined in section 1395w-23(c)(6) of this title.

(4) Medicare+Choice monthly basic beneficiary premium; Medicare+Choice monthly supplemental beneficiary premium

The terms "Medicare+Choice monthly basic beneficiary premium" and "Medicare+Choice monthly supplemental beneficiary premium" are defined in section 1395w-24(a)(2) of this title.

(d) Coordinated acute and long-term care benefits under a Medicare+Choice plan

Nothing in this part shall be construed as preventing a State from coordinating benefits under a medicaid plan under subchapter XIX of this chapter with those provided under a Medicare+Choice plan in a manner that assures continuity of a full-range of acute care and long-term care services to poor elderly or disabled individuals eligible for benefits under this title and under such plan.

(e) Restriction on enrollment for certain Medicare+Choice plans

(1) In general

In the case of a Medicare+Choice religious fraternal benefit society plan described in paragraph (2), notwithstanding any other provision of this part to the contrary and in accordance with regulations of the Secretary, the society offering the plan may restrict the enrollment of individuals under this part to individuals who are members of the church, convention, or group described in paragraph (3)(B) with which the society is affiliated.

(2) Medicare+Choice religious fraternal benefit society plan described

For purposes of this subsection, a Medicare+Choice religious fraternal benefit society plan described in this paragraph is a Medicare+Choice plan described in section 1395w-2I(a)(2) of this title that--

(A) is offered by a religious fraternal benefit society described in paragraph (3) only to members of the church, convention, or group described in paragraph (3)(B); and

(B) permits all such members to enroll under the plan without regard to health status-related factors. Nothing in this subsection shall be construed as waiving any plan requirements relating to financial solvency.

(3) Religious fraternal benefit society defined

For purposes of paragraph (2)(A), a "religious fraternal benefit society" described in this section is an organization that--

(A) is described in section 501(c)(8) of Title 26 and is exempt from taxation under section 501(a) of such Title 26;

(B) is affiliated with, carries out the tenets of, and shares a religious bond with, a church or convention or association of churches or an affiliated group of churches;

(C) offers, in addition to a Medicare+Choice religious fraternal benefit society plan, health coverage to individuals not entitled to benefits under this title who are members of such church, convention, or group; and

(D) does not impose any limitation on membership in the society based on any health status-related factor.

(4) Payment adjustment

Under regulations of the Secretary, in the case of individuals enrolled under this part under a Medicare+Choice religious fraternal benefit society plan described in paragraph (2), the Secretary shall provide for such adjustment to the payment amounts otherwise established under section 1395w-24 of this title as may be appropriate to assure an appropriate payment

level, taking into account the actuarial characteristics and experience of such individuals.

42 U.S.C. § 1395mm. Payments to health maintenance organizations and competitive medical plans

(a) Rates and adjustments

(1)(A) The Secretary shall annually determine, and shall announce (in a manner intended to provide notice to interested parties) not later than September 7 before the calendar year concerned--

(i) a per capita rate of payment for each class of individuals who are enrolled under this section with an eligible organization which has entered into a risk-sharing contract and who are entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter, and

(ii) a per capita rate of payment for each class of individuals who are so enrolled with such an organization and who are enrolled under part B of this subchapter only.

For purposes of this section, the term "risk-sharing contract" means a contract entered into under subsection (g) of this section and the term "reasonable cost reimbursement contract" means a contract entered into under subsection (h) of this section.

(B) The Secretary shall define appropriate classes of members, based on age, disability status, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such classes, if such changes will improve the determination of actuarial equivalence.

(C) The annual per capita rate of payment for each such class shall be equal to 95 percent of the adjusted average per capita cost (as defined in paragraph (4)) for that class.

(D) In the case of an eligible organization with a risk-sharing contract, the Secretary shall make monthly payments in advance and in accordance with the rate determined under subparagraph (C) and except as provided in subsection (g)(2)

of this section, to the organization for each individual enrolled with the organization under this section.

(E)(i) The amount of payment under this paragraph may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled in the plan under this section and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

(ii)(I) Subject to subclause (II), the Secretary may make retroactive adjustments under clause (i) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with an eligible organization (which has a risk-sharing contract under this section) under a health benefit plan operated, sponsored, or contributed to by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the plan under this section, except that for purposes of making such retroactive adjustments under this clause, such period may not exceed 90 days.

(II) No adjustment may be made under subclause (I) with respect to any individual who does not certify that the organization provided the individual with the explanation described in subsection (c)(3)(E) of this section at the time the individual enrolled with the organization.

(F)(i) At least 45 days before making the announcement under subparagraph (A) for a year (beginning with the announcement for 1991), the Secretary shall provide for notice to eligible organizations of proposed changes to be made in the methodology or benefit coverage assumptions from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity to comment on such proposed changes.

(ii) In each announcement made under subparagraph (A) for a year (beginning with the announcement for 1991), the

Secretary shall include an explanation of the assumptions (including any benefit coverage assumptions) and changes in methodology used in the announcement in sufficient detail so that eligible organizations can compute per capita rates of payment for classes of individuals located in each county (or equivalent area) which is in whole or in part within the service area of such an organization.

(2) With respect to any eligible organization which has entered into a reasonable cost reimbursement contract, payments shall be made to such plan in accordance with subsection (h)(2) of this section rather than paragraph (1).

(3) Subject to subsections (c)(2)(B)(ii) and (c)(7) of this section, payments under a contract to an eligible organization under paragraph (1) or (2) shall be instead of the amounts which (in the absence of the contract) would be otherwise payable, pursuant to sections 1395f(b) and 13951 (a) of this title, for services furnished by or through the organization to individuals enrolled with the organization under this section.

(4) For purposes of this section, the term "adjusted average per capita cost" means the average per capita amount that the Secretary estimates in advance (on the basis of actual experience, or retrospective actuarial equivalent based upon an adequate sample and other information and data, in a geographic area served by an eligible organization or in a similar area, with appropriate adjustments to assure actuarial equivalence) would be payable in any contract year for services covered under parts A and B of this subchapter, or part B only, and types of expenses otherwise reimbursable under parts A and B of this subchapter, or part B only (including administrative costs incurred by organizations described in sections 1395h and 1395u of this title), if the services were to be furnished by other than an eligible organization or, in the case of services covered only under section 1395x(s)(2)(H) of this title, if the services were to be

furnished by a physician or as an incident to a physician's service.

(5) The payment to an eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The portion of that payment to the organization for a month to be paid by each trust fund shall be determined as follows:

(A) In regard to expenditures by eligible organizations having risk-sharing contracts, the allocation shall be determined each year by the Secretary based on the relative weight that benefits from each fund contribute to the adjusted average per capita cost.

(B) In regard to expenditures by eligible organizations operating under a reasonable cost reimbursement contract, the initial allocation shall be based on the plan's most recent budget, such allocation to be adjusted, as needed, after cost settlement to reflect the distribution of actual expenditures. The remainder of that payment shall be paid by the former trust fund.

(6) Subject to subsections (c)(2)(B)(ii) and (c)(7) of this section, if an individual is enrolled under this section with an eligible organization having a risk-sharing contract, only the eligible organization shall be entitled to receive payments from the Secretary under this subchapter for services furnished to the individual.

(b) Definitions; requirements

For purposes of this section, the term "eligible organization" means a public or private entity (which may be a health maintenance organization or a competitive medical plan), organized under the laws of any State, which—

(1) is a qualified health maintenance organization (as defined in section 300e-9(d) of this title), or

(2) meets the following requirements:

(A) The entity provides to enrolled members at least the following health care services:

(i) Physicians' services performed by physicians (as defined in section 1395x(r)(1) of this title).

(ii) Inpatient hospital services.

(iii) Laboratory, X-ray, emergency, and preventive services.

(iv) Out-of-area coverage.

(B) The entity is compensated (except for deductibles, coinsurance, and copayments) for the provision of health care services to enrolled members by a payment which is paid on a periodic basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent, or kind of health care service actually provided to a member.

(C) The entity provides physicians' services primarily (i) directly through physicians who are either employees or partners of such organization, or (ii) through contracts with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis).

(D) The entity assumes full financial risk on a prospective basis for the provision of the health care services listed in subparagraph (A), except that such entity may--

(i) obtain insurance or make other arrangements for the cost of providing to any enrolled member health care services listed in subparagraph (A) the aggregate value of_ which exceeds $5,000 in any year,

(ii) obtain insurance or make other arrangements for the cost of health care service listed in subparagraph (A) provided to its enrolled members other than through the entity because medical necessity required their provision before they could be secured through the entity,

(iii) obtain insurance or make other arrangements for not more than 90 percent of the amount by which its costs for any

of its fiscal years exceed 115 percent of its income for such fiscal year, and

(iv) make arrangements with physicians or other health professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions.

(E) The entity has made adequate provision against the risk of insolvency, which provision is satisfactory to the Secretary.

Paragraph (2)(A)(ii) shall not apply to an entity which had contracted with a single State agency administering a State plan approved under subchapter XIX of this chapter for the provision of services (other than inpatient hospital services) to individuals eligible for such services under such State plan on a prepaid risk basis prior to 1970.

(c) Enrollment in plan; duties of organization to enrollees

(1) The Secretary may not enter into a contract under this section with an eligible organization unless it meets the requirements of this subsection and subsection (e) of this section with respect to members enrolled under this section.

(2)(A) The organization must provide to members enrolled under this section, through providers and other persons that meet the applicable requirements of this subchapter and part A of subchapter XI of this chapter--

(i) only those services covered under parts A and B of this subchapter, for those members entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter, or

(ii) only those services covered under part B of this subchapter, for those members enrolled only under such part, which are available to individuals residing in the geographic area served by the organization, except that (I) the organization may provide such members with such additional health care services as the members may elect, at their option,

to have covered, and (II) in the case of an organization with a risk-sharing contract, the organization may provide such members with such additional health care services as the Secretary may approve. The Secretary shall approve any such additional health care services which the organization proposes to offer to such members, unless the Secretary determines that including such additional services will substantially discourage enrollment by covered individuals with the organization.

(B) If there is a national coverage determination made in the period beginning on the date of an announcement under subsection (a)(1)(A) of this section and ending on the date of the next announcement under such subsection that the Secretary projects will result in a significant change in the costs to the organization of providing the benefits that are the subject of such national coverage determination and that was not incorporated in the determination of the per capita rate of payment included in the announcement made at the beginning of such period--

(i) such determination shall not apply to risk-sharing contracts under this section until the first contract year that begins after the end of such period; and

(ii) if such coverage determination provides for coverage of additional benefits or under additional circumstances, subsection (a)(3) of this section shall not apply to payment for such additional benefits or benefits provided under such additional circumstances until the first contract year that begins after the end of such period, unless otherwise required by law.

(3)(A)(i) Each eligible organization must have an open enrollment period, for the enrollment of individuals under this section, of at least 30 days duration every year and including the period or periods specified under clause (ii), and must provide that at any time during which enrollments are accepted, the organization will accept up to the limits of its

capacity (as determined by the Secretary) and without restrictions, except as may be authorized in regulations, individuals who are eligible to enroll under subsection (d) of this section in the order in which they apply for enrollment, unless to do so would result in failure to meet the requirements of subsection (f) of this section or would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the population in the geographic area served by the organization.

(ii)(I) If a risk-sharing contract under this section is not renewed or is otherwise terminated, eligible organizations with risk-sharing contracts under this section and serving a part of the same service area as under the terminated contract are required to have an open enrollment period for individuals who were enrolled under the terminated contract as of the date of notice of such termination. If a risk-sharing contract under this section is renewed in a manner that discontinues coverage for individuals residing in part of the service area, eligible organizations with risk-sharing contracts under this section and enrolling individuals residing in that part of the service area are required to have an open enrollment period for individuals residing in the part of the service area who were enrolled under the contract as of the date of notice of such discontinued coverage.

(II) The open enrollment periods required under subclause (I) shall be for 30 days and shall begin 30 days after the date that the Secretary provides notice of such requirement.

(III) Enrollment under this clause shall be effective 30 days after the end of the open enrollment period, or, if the Secretary determines that such date is not feasible, such other date as the Secretary specifies.

(B) An individual may enroll under this section with an eligible organization in such manner as may be prescribed in

regulations and may terminate his enrollment with the eligible organization as of the beginning of the first calendar month following the date on which the request is made for such termination (or, in the case of financial insolvency of the organization, as may be prescribed by regulations) or, in the case of such an organization with a reasonable cost reimbursement contract, as may be prescribed by regulations. In the case of an individual's termination of enrollment, the organization shall provide the individual with a copy of the written request for termination of enrollment and a written explanation of the period (ending on the effective date of the termination) during which the individual continues to be enrolled with the organization and may not receive benefits under this subchapter other than through the organization.

(C) The Secretary may prescribe the procedures and conditions under which an eligible organization that has entered into a contract with the Secretary under this subsection may inform individuals eligible to enroll under this section with the organization about the organization, or may enroll such individuals with the organization. No brochures, application forms, or other promotional or informational material may be distributed by an organization to (or for the use of) individuals eligible to enroll with the organization under this section unless (i) at least 45 days before its distribution, the organization has submitted the material to the Secretary for review and (ii) the Secretary has not disapproved the distribution of the material. The Secretary shall review all such material submitted and shall disapprove such material if the Secretary determines, in the Secretary's discretion, that the material is materially inaccurate or misleading or otherwise makes a material misrepresentation.

(D) The organization must provide assurances to the Secretary that it will not expel or refuse to re-enroll any such individual because of the individual's health status or requirements for health care services, and that it will notify

each such individual of such fact at the time of the individual's enrollment.

(E) Each eligible organization shall provide each enrollee, at the time of enrollment and not less frequently than annually thereafter, an explanation of the enrollee's rights under this section, including an explanation of--

(i) the enrollee's rights to benefits from the organization,

(ii) the restrictions on payments under this subchapter for services furnished other than by or through the organization,

(iii) out-of-area coverage provided by the organization,

(iv) the organization's coverage of emergency services and urgently needed care, and

(v) appeal rights of enrollees.

(F) Each eligible organization that provides items and services pursuant to a contract under this section shall provide assurances to the Secretary that in the event the organization ceases to provide such items and services, the organization shall provide or arrange for supplemental coverage of benefits under this subchapter related to a pre-existing condition with respect to any exclusion period, to all individuals enrolled with the entity who receive benefits under this subchapter, for the lesser of six months or the duration of such period.

(G)(i) Each eligible organization having a risk-sharing contract under this section shall notify individuals eligible to enroll with the organization under this section and individuals enrolled with the organization under this section that--

(I) the organization is authorized by law to terminate or refuse to renew the contract, and

(II) termination or nonrenewal of the contract may result in termination of the enrollments of individuals enrolled with the organization under this section.

(ii) The notice required by clause (i) shall be included in--

(I) any marketing materials described in subparagraph (C) that are distributed by an eligible organization to

individuals eligible to enroll under this section with the organization, and

(II) any explanation provided to enrollees by the organization pursuant to subparagraph (E).

(4) The organization must--

(A) make the services described in paragraph (2) (and such other health care services as such individuals have contracted for) (i) available and accessible to each such individual, within the area served by the organization, with reasonable promptness and in a manner which assures continuity, and (ii) when medically necessary, available and accessible twenty-four hours a day and seven days a week, and

(B) provide for reimbursement with respect to services which are described in subparagraph (A) and which are provided to such an individual other than through the organization, if (i) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition and (ii) it was not reasonable given the circumstances to obtain the services through the organization.

(5)(A) The organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and members enrolled with the organization under this section.

(B) A member enrolled with an eligible organization under this section who is dissatisfied by reason of his failure to receive any health service to which he believes he is entitled and at no greater charge than he believes he is required to pay is entitled, if the amount in controversy is $100 or more, to a hearing before the Secretary to the same extent as is provided in section 405(b) of this title, and in any such hearing the Secretary shall make the eligible organization a party. If the amount in controversy is $1,000 or more, the individual or eligible organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as

provided in section 405(g) of this title, and both the individual and the eligible organization shall be entitled to be parties to that judicial review. In applying sections 405(b) and 405(g) of this title as provided in this subparagraph, and in applying section 405(1) of this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

(6) The organization must have arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for health care services it provides to such individuals, which program (A) stresses health outcomes and (B) provides review by physicians and other health care professionals of the process followed in the provision of such health care services.

(7) A risk-sharing contract under this section shall provide that in the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1395ww(d)(1)(B) of this title) as of the effective date of the individual's--

(A) enrollment with an eligible organization under this section--

(i) payment for such services until the date of the individual's discharge shall be made under this subchapter as if the individual were not enrolled with the organization,

(ii) the organization shall not be financially responsible for payment for such services until the date after the date of the individual's discharge, and

(iii) the organization shall nonetheless be paid the full amount otherwise payable to the organization under this section; or

(B) termination of enrollment with an eligible organization under this section--

(i) the organization shall be financially responsible for payment for such services after such date and until the date of the individual's discharge,

(ii) payment for such services during the stay shall not be made under section 1395ww(d) of this title, and

(iii) the organization shall not receive any payment with respect to the individual under this section during the period the individual is not enrolled.

(8) A contract under this section shall provide that the eligible organization shall meet the requirement of section 1395cc(f) of this title (relating to maintaining written policies and procedures respecting advance directives).

(d) Right to enroll with contracting organization in geographic area

Subject to the provisions of subsection (c)(3) of this section, every individual entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter or enrolled under part B of this subchapter only (other than an individual medically determined to have end-stage renal disease) shall be eligible to enroll under this section with any eligible organization with which the Secretary has entered into a contract under this section and which serves the geographic area in which the individual resides.

(e) Limitation on charges; election of coverage; "adjusted community rate" defined; workmen's compensation and insurance benefits

(1) In no case may--

(A) the portion of an eligible organization's premium rate and the actuarial value of its deductibles, coinsurance, and copayments charged (with respect to services covered under parts A and B of this subchapter) to individuals who are enrolled under this section with the organization and who are entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter, or

(B) the portion of its premium rate and the actuarial value of its deductibles, coinsurance, and copayments charged (with respect to services covered under part B of this subchapter) to individuals who are enrolled under this section with the organization and enrolled under part B of this subchapter only exceed the actuarial value of the coinsurance and deductibles that would be applicable on the average to individuals enrolled under this section with the organization (or, if the Secretary finds that adequate data are not available to determine that actuarial value, the actuarial value of the coinsurance and deductibles applicable on the average to individuals in the area, in the State, or in the United States, eligible to enroll under this section with the organization, or other appropriate data) and entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter, or enrolled under part B only, respectively, if they were not members of an eligible organization.

(2) If the eligible organization provides to its members enrolled under this section services in addition to services covered under parts A and B of this subchapter, election of coverage for such additional services (unless such services have been approved by the Secretary under subsection (c)(2) of this section) shall be optional for such members and such organization shall furnish such members with information on the portion of its premium rate or other charges applicable to such additional services. In no case may the sum of--

(A) the portion of such organization's premium rate charged, with respect to such additional services, to members enrolled under this section, and

(B) the actuarial value of its deductibles, coinsurance, and copayments charged, with respect to such services to such members exceed the adjusted community rate for such services.

(3) For purposes of this section, the term "adjusted community rate" for a service or services means, at the election of an eligible organization, either--

(A) the rate of payment for that service or services which the Secretary annually determines would apply to a member enrolled under this section with an eligible organization if the rate of payment were determined under a "community rating system" (as defined in section 300e-1(8) of this title, other than subparagraph (C)), or

(B) such portion of the weighted aggregate premium, which the Secretary annually estimates would apply to a member enrolled under this section with the eligible organization, as the Secretary annually estimates is attributable to that service or services, but adjusted for differences between the utilization characteristics of the members enrolled with the eligible organization under this section and the utilization characteristics of the other members of the organization (or, if the Secretary finds that adequate data are not available to adjust for those differences, the differences between the utilization characteristics of members in other eligible organizations, or individuals in the area, in the State, or in the United States, eligible to enroll under this section with an eligible organization and the utilization characteristics of the rest of the population in the area, in the State, or in the United States, respectively).

(4) Notwithstanding any other provision of law, the eligible organization may (in the case of the provision of services to a member enrolled under this section for an illness or injury for which the member is entitled to benefits under a workmen's compensation law or plan of the United States or a State, under an automobile or liability insurance policy or plan, including a self-insured plan, or under no fault insurance) charge or authorize the provider of such services to charge, in accordance with the charges allowed under such law or policy--

(A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services, or

(B) such member to the extent that the member has been paid under such law, plan, or policy for such services.

(f) Membership requirements

(1) For contract periods beginning before January 1, 1999, each eligible organization with which the Secretary enters into a contract under this section shall have, for the duration of such contract, an enrolled membership at least one-half of which consists of individuals who are not entitled to benefits under this subchapter.

(2) Subject to paragraph (4), the Secretary may modify or waive the requirement imposed by paragraph (1) only--

(A) to the extent that more than 50 percent of the population of the area served by the organization consists of individuals who are entitled to benefits under this subchapter or under a State plan approved under subchapter XIX of this chapter, or

(B) in the case of an eligible organization that is owned and operated by a governmental entity, only with respect to a period of three years beginning on the date the organization first enters into a contract under this section, and only if the organization has taken and is making reasonable efforts to enroll individuals who are not entitled to benefits under this subchapter or under a State plan approved under subchapter XIX of this chapter.

(3) If the Secretary determines that an eligible organization has failed to comply with the requirements of this subsection, the Secretary may provide for the suspension of enrollment of individuals under this section or of payment to the organization under this section for individuals newly enrolled with the organization, after the date the Secretary notifies the organization of such noncompliance.

(4) Effective for contract periods beginning after December 31, 1996, the Secretary may waive or modify the requirement imposed by paragraph (1) to the extent the Secretary finds that it is in the public interest.

(g) Risk-sharing contract

(1) The Secretary may enter a risk-sharing contract with any eligible organization, as defined in subsection (b) of this section, which has at least 5,000 members, except that the Secretary may enter into such a contract with an eligible organization that has fewer members if the organization primarily serves members residing outside of urbanized areas.

(2) Each risk-sharing contract shall provide that--

(A) if the adjusted community rate, as defined in subsection (e)(3) of this section, for services under parts A and B of this subchapter (as reduced for the actuarial value of the coinsurance and deductibles under those parts) for members enrolled under this section with the organization and entitled to benefits under part A of this subchapter and enrolled in part B of this subchapter, or

(B) if the adjusted community rate for services under part B of this subchapter (as reduced for the actuarial value of the coinsurance and deductibles under that part) for members enrolled under this section with the organization and entitled to benefits under part B of this subchapter only is less than the average of the per capita rates of payment to be made under subsection (a)(1) of this section at the beginning of an annual contract period for members enrolled under this section with the organization and entitled to benefits under part A of this subchapter and enrolled in part B of this subchapter, or enrolled in part B of this subchapter only, respectively, the eligible organization shall provide to members enrolled under a risk-sharing contract under this section with the organization and entitled to benefits under part A of this subchapter and enrolled in part B of this subchapter, or enrolled in part B of this subchapter only, respectively, the

additional benefits described in paragraph (3) which are selected by the eligible organization and which the Secretary finds are at least equal in value to the difference between that average per capita payment and the adjusted community rate (as so reduced); except that this paragraph shall not apply with respect to any organization which elects to receive a lesser payment to the extent that there is no longer a difference between the average per capita payment and adjusted community rate (as so reduced) and except that an organization (with the approval of the Secretary) may provide that a part of the value of such additional benefits be withheld and reserved by the Secretary as provided in paragraph (5). If the Secretary finds that there is insufficient enrollment experience to determine an average of the per capita rates of payment to be made under subsection (a)(1) of this section at the beginning of a contract period, the Secretary may determine such an average based on the enrollment experience of other contracts entered into under this section.

(3) The additional benefits referred to in paragraph (2) are--

(A) the reduction of the premium rate or other charges made with respect to services furnished by the organization to members enrolled under this section, or

(B) the provision of additional health benefits, or both.

(4) Repealed. Pub.L. 100-203, Title IV, § 4012(b), Dec. 22, 1987, 101 Stat. 1330-61

(5) An organization having a risk-sharing contract under this section may (with the approval of the Secretary) provide that a part of the value of additional benefits otherwise required to be provided by reason of paragraph (2) be withheld and reserved in the Federal Hospital Insurance Trust Fund and in the Federal Supplementary Medical Insurance Trust Fund (in such proportions as the Secretary determines to be appropriate) by the Secretary for subsequent annual contract periods, to the extent required to stabilize and prevent undue fluctuations in the additional benefits offered in those

subsequent periods by the organization in accordance with paragraph (3). Any of such value of additional benefits which is not provided to members of the organization in accordance with paragraph (3) prior to the end of such period, shall revert for the use of such trust funds.

(6)(A) A risk-sharing contract under this section shall require the eligible organization to provide prompt payment (consistent with the provisions of sections 1395h(c)(2) and 1395u(c)(2) of this title) of claims submitted for services and supplies furnished to individuals pursuant to such contract, if the services or supplies are not furnished under a contract between the organization and the provider or supplier.

(B) In the case of an eligible organization which the Secretary determines, after notice and opportunity for a hearing, has failed to make payments of amounts in compliance with subparagraph (A), the Secretary may provide for direct payment of the amounts owed to providers and suppliers for such covered services furnished to individuals enrolled under this section under the contract. If the Secretary provides for such direct payments, the Secretary shall provide for an appropriate reduction in the amount of payments otherwise made to the organization under this section to reflect the amount of the Secretary's payments (and costs incurred by the Secretary in making such payments).

42 U.S.C. § 1395ss. Certification of medicare supplemental health insurance policies

(s) Coverage of pre-existing [FN3] conditions

(1) If a medicare supplemental policy replaces another medicare supplemental policy, the issuer of the replacing policy shall waive any time periods applicable to preexisting conditions, waiting period, elimination periods and probationary periods in the new medicare supplemental policy for similar benefits to the extent such time was spent under the original policy.

(2)(A) The issuer of a medicare supplemental policy may not deny or condition the issuance or effectiveness of a medicare supplemental policy, or discriminate in the pricing of the policy, because of health status, claims experience, receipt of health care, or medical condition in the case of an individual for whom an application is submitted prior to or during the 6 month period beginning with the first month as of the first day on which the individual is 65 years of age or older and is enrolled for benefits under part B of this subchapter.

(B) Subject to subparagraphs (C) and (D), subparagraph (A) shall not be construed as preventing the exclusion of benefits under a policy, during its first 6 months, based on a pre-existing [FN3] condition for which the policyholder received treatment or was otherwise diagnosed during the 6 months before the policy became effective.

(C) If a medicare supplemental policy or certificate replaces another such policy or certificate which has been in effect for 6 months or longer, the replacing policy may not provide any time period applicable to pre-existing [FN3] conditions, waiting periods, elimination periods, and probationary periods in the new policy or certificate for similar benefits.

(D) In the case of a policy issued during the 6-month period described in subparagraph (A) to an individual who is 65 years of age or older as of the date of issuance and who as of the date of the application for enrollment has a continuous period of creditable coverage (as defined in section 300gg(c) of this title) of--

(i) at least 6 months, the policy may not exclude benefits based on a pre- existing [FN3] condition; or

(ii) less than 6 months, if the policy excludes benefits based on a preexisting condition, the policy shall reduce the period of any preexisting condition exclusion by the aggregate of the periods of creditable coverage (if any, as so defined) applicable to the individual as of the enrollment date.

The Secretary shall specify the manner of the reduction under clause (ii), based upon the rules used by the Secretary in carrying out section 300gg(a)(3) of this title.

(3)(A) The issuer of a medicare supplemental policy--

(i) may not deny or condition the issuance or effectiveness of a medicare supplemental policy described in subparagraph (C) that is offered and is available for issuance to new enrollees by such issuer;

(ii) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

(iii) may not impose an exclusion of benefits based on a pre-existing [FN3] condition under such policy, in the case of an individual described in subparagraph (B) who seeks to enroll under the policy during the period specified in subparagraph (E) and who submits evidence of the date of termination or disenrollment along with the application for such medicare supplemental policy.

(B) An individual described in this subparagraph is an individual described in any of the following clauses:

(i) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the

benefits under this subchapter and the plan terminates or ceases to provide all such supplemental health benefits to the individual.

(ii) The individual is enrolled with a Medicare+Choice organization under a Medicare+Choice plan under part C of this subchapter, and there are circumstances permitting discontinuance of the individual's election of the plan under the first sentence of section 1395w-21(e)(4) of this title or the individual is 65 years of age or older and is enrolled with a PACE provider under section 1395eee of this title, and there are circumstances that would permit the discontinuance of the individual's enrollment with such provider under circumstances that are similar to the circumstances that would permit discontinuance of the individual's election under the first sentence of such section if such individual were enrolled in a Medicare+Choice plan.

(iii) The individual is enrolled with an eligible organization under a contract under section 1395mm of this title, a similar organization operating under demonstration project authority, effective for periods before April 1, 1999, with an organization under an agreement under section 13951(a)(1)(A) of this title, or with an organization under a policy described in subsection (t) of this section, and such enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under the first sentence of section 1395w-21(e)(4) of this title and, in the case of a policy described in subsection (t) of this section, there is no provision under applicable State law for the continuation or conversion of coverage under such policy.

(iv) The individual is enrolled under a medicare supplemental policy under this section and such enrollment ceases because--

(I) of the bankruptcy or insolvency of the issuer or because of other involuntary termination of coverage or enrollment under such policy and there is no provision under

applicable State law for the continuation or conversion of such coverage;

(II) the issuer of the policy substantially violated a material provision of the policy; or

(III) the issuer (or an agent or other entity acting on the issuer's behalf) materially misrepresented the policy's provisions in marketing the policy to the individual.

(v) The individual--

(I) was enrolled under a medicare supplemental policy under this section,

(II) subsequently terminates such enrollment and enrolls, for the first time, with any Medicare+Choice organization under a Medicare+Choice plan under part C of this subchapter, any eligible organization under a contract under section 1395mm of this title, any similar organization operating under demonstration project authority, any PACE provider under section 1395eee of this title, or any policy described in subsection (t) of this section, and

(III) the subsequent enrollment under subclause (II) is terminated by the enrollee during any period within the first 12 months of such enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1395w-21(e) of this title).

(vi) The individual, upon first becoming eligible for benefits under part A of this subchapter at age 65, enrolls in a Medicare+Choice plan under part C of this subchapter or in a PACE program under section 1395eee of this title, and disenrolls from such plan or such program by not later than 12 months after the effective date of such enrollment.

(C)(i) Subject to clauses (ii) and (iii), a medicare supplemental policy described in this subparagraph is a medicare supplemental policy which has a benefit package classified as 'A', 'B', 'C', or 'F' under the standards established under subsection (p)(2) of this section.

(ii) Only for purposes of an individual described in subparagraph (B)(v), a medicare supplemental policy described in this subparagraph is the same medicare supplemental policy referred to in such subparagraph in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in clause (i).

(iii) Only for purposes of an individual described in subparagraph (B)(vi), a medicare supplemental policy described in this subparagraph shall include any medicare supplemental policy.

(iv) For purposes of applying this paragraph in the case of a State that provides for offering of benefit packages other than under the classification referred to in clause (i), the references to benefit packages in such clause are deemed references to comparable benefit packages offered in such State.

(D) At the time of an event described in subparagraph (B) because of which an individual ceases enrollment or loses coverage or benefits under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, the insurer offering the policy, or the administrator of the plan, respectively, shall notify the individual of the rights of the individual under this paragraph, and obligations of issuers of medicare supplemental policies, under subparagraph (A).

(E) For purposes of subparagraph (A), the time period specified in this subparagraph is--

(i) in the case of an individual described in subparagraph (B)(i), the period beginning on the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if no such notice is received, notice that a claim has been denied because of such a termination or cessation) and ending on the date that is 63 days after the applicable notice;

(ii) in the case of an individual described in clause (ii), (iii), (v), or (vi) of subparagraph (B) whose enrollment is terminated involuntarily, the period beginning on the date that the individual receives a notice of termination and ending on the date that is 63 days after the date the applicable coverage is terminated;

(iii) in the case of an individual described in subparagraph (B)(iv)(I), the period beginning on the earlier of (I) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice, if any, and (II) the date that the applicable coverage is terminated, and ending on the date that is 63 days after the date the coverage is terminated;

(iv) in the case of an individual described in clause (ii), (iii),(iv)(II), (iv)(III), (v), or (vi) of subparagraph (B) who disenrolls voluntarily, the period beginning on the date that is 60 days before the effective date of the disenrollment and ending on the date that is 63 days after such effective date; and

(v) in the case of an individual described in subparagraph (B) but not described in the preceding provisions of this subparagraph, the period beginning on the effective date of the disenrollment and ending on the date that is 63 days after such effective date.

(F)(i) Subject to clause (ii), for purposes of this paragraph--

(I) in the case of an individual described in subparagraph (B)(v) (or deemed to be so described, pursuant to this subparagraph) whose enrollment with an organization or provider described in subclause (II) of such subparagraph is involuntarily terminated within the first 12 months of such enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, such subsequent enrollment shall be deemed to be an initial enrollment described in such subparagraph; and

(II) in the case of an individual described in clause (vi) of subparagraph (B) (or deemed to be so described, pursuant to this subparagraph) whose enrollment with a plan or in a program described in such clause is involuntarily terminated within the first 12 months of such enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, such subsequent enrollment shall be deemed to be an initial enrollment described in such clause.

(ii) For purposes of clauses (v) and (vi) of subparagraph (B), no enrollment of an individual with an organization or provider described in clause (v)(II), or with a plan or in a program described in clause (vi), may be deemed to be an initial enrollment under this clause after the 2-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan, or program.

(4) Any issuer of a medicare supplemental policy that fails to meet the requirements of this subsection is subject to a civil money penalty of not to exceed $5,000 for each such failure. The provisions of section 1320a-7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

Supreme Court, U.S.
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No. 01-1372

In the Supreme Court of the United States

MINNESOTA SENIOR FEDERATION, METROPOLITAN REGION, ET AL., PETITIONERS

v.

UNITED STATES OF AMERICA, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF FOR THE RESPONDENTS IN OPPOSITION

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QUESTION PRESENTED

Whether the system that Congress has established for paying managed care organizations under the "Medicare + Choice" program violates the constitutional right to travel.

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BRIEF FOR THE RESPONDENTS IN OPPOSITION

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-9a) is reported at 273 F.3d 805. The opinion of the district court (Pet. App. 1b-27b) is reported at 102 F. Supp. 2d 1115.

JURISDICTION

The judgment of the court of appeals was entered on December 13, 2001. The petition for a writ of certiorari was filed on March 13, 2002. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. a. The Medicare program was established in 1965 by Title XVIII of the Social Security Act, Pub. L. No. 89-97, 79 Stat. 291. The program provides medical coverage for disabled persons, persons who are at least 65 years old, and persons with end stage renal disease who meet specified eligibility requirements. Those persons are automatically enrolled in Medicare Part A, which pays for hospital and other institutional health care expenses. See 42 U.S.C. 1395 *et seq.*

Persons who are covered by Medicare Part A may purchase supplementary insurance for additional medical services (such as physicians services) under Medicare Part B by paying a monthly premium to the Federal Supplementary Medical Insurance Trust Fund. 42 U.S.C. 1395j to 1395w-4.

Under the traditional fee-for-service payment system, Medicare reimburses a provider for each service rendered. The amount of Medicare reimbursement depends, in part, on the geographic area in which the provider works. See, *e.g.*, 42 U.S.C. 1395w-4(e) (setting out "[g]eographic adjustment factors" for payment for physicians' services). The geographic adjustment factors are intended to reflect geographic variation in the cost of providing services. See, *e.g.*, 42 U.S.C. 1395w-4(e)(1)(A)(i) (requiring the Secretary to establish "an index which reflects the relative costs of the mix of goods and services comprising practice expenses * * * in the different fee schedule areas compared to the national average of such costs").

b. As an alternative to the fee-for-service system, Medicare beneficiaries may instead enroll with a managed care organization (such as an HMO), which enters into a payment contract with Medicare. From 1972

through 1998, such contracts were governed by Section 1876 of the Social Security Act, 42 U.S.C. 1395mm.

Section 1876 provided for two types of contracts, "cost" contracts under which a managed care organization was reimbursed for its reported costs (subject to auditing for reasonableness), and "risk" contracts under which a fixed monthly payment was made by Medicare. See 42 U.S.C. 1395mm(a), (g) and (h); see also 42 C.F.R. 417.530-417.536 (cost contract), 417.580-417.598 (risk contract).

Under a Section 1876 risk contract, the monthly capitation payment was based on an amount referred to as the "adjusted average per capita cost" (AAPCC). 42 U.S.C. 1395mm(a)(4); 42 C.F.R. 417.584. The AAPCC was Medicare's estimate of the average per capita amount it would cost to treat a beneficiary under the fee-for-service system. See 42 U.S.C. 1395mm(a)(4) ("the term 'adjusted average per capita cost' means the average per capita amount that the Secretary estimates in advance (on the basis of actual experience, or retrospective actuarial equivalent based upon an adequate sample and other information and data, in a geographic area served by an eligible organization or in a similar area, with appropriate adjustments to assure actuarial equivalence) would be payable in any contract year for services covered under parts A and B of this subchapter").

Because the AAPCC was intended to approximate the amount that Medicare would pay under the fee-for-service system, the AAPCC (like reimbursement under the fee-for-service system) depended in part on the geographic area in which the managed care organization was located. 42 C.F.R. 417.588(c)(1) ("[The Health Care Financing Administration (HCFA)] makes an adjustment to reflect the relative level of Medicare expendi-

tures for beneficiaries who reside in the [managed care organization's] geographic area (or a similar area). This adjustment is based on reimbursement for Medicare covered services and uses the most accurate and timely data that pertain to the [managed care organization's] geographic area and that is available to [HCFA] when it makes the determination."). The AAPCC also took into account other demographic factors, such as the age, sex and disability status of the managed care organization's enrollees. 42 C.F.R. 417.588(c)(3).

For each Medicare beneficiary enrolled in a managed care organization with a risk contract, Medicare would pay the organization 95% of the AAPCC rate corresponding to the demographic class to which each beneficiary was assigned. 42 U.S.C. 1395mm(a)(1)(C); 42 C.F.R. 417.584(b)(1). If the managed care organization's costs exceeded the Medicare payment, the organization was at risk for the difference. If the Medicare payment exceeded the market cost of the managed care organization's benefits package (adjusted for the demographics of the Medicare population), the organization was required to pass the "savings" along to its enrollees.

Specifically, a managed care organization was required to submit to HCFA its "adjusted community rate" (ACR) for the Medicare package of services. 42 U.S.C. 1395mm(e)(3); 42 C.F.R. 417.594. The ACR represented the organization's commercial premium charge for the Medicare benefits package, adjusted for the higher utilization of services expected from the Medicare population. If the ACR was lower than the Medicare payment, the managed care organization was required to use the difference to provide additional

benefits or reduced premiums or cost-sharing. 42 U.S.C. 1395mm(g)(2).[1]

c. The Balanced Budget Act of 1997 (BBA) provided that Section 1876 risk contracts could not be renewed after January 1, 1999. 42 U.S.C. 1395mm(k)(1)(B) (Supp. V 1999). The Medicare + Choice program replaced the Section 1876 risk contracts, as of that date. 42 U.S.C. 1395w-21 to 1395w-28 (Supp. V 1999).[2]

As relevant here, the Medicare + Choice program altered the formula by which capitation payments for managed care organizations with risk contracts are calculated. 42 U.S.C. 1395w-23(c) (Supp. V 1999). HCFA had observed that the AAPCC "had been legitimately criticized for its wide range of payment rates among geographic regions—in some cases it varied by over 20 percent between adjacent counties." 63 Fed. Reg. 34,968, 35,004 (1998). Congress addressed that concern in the Medicare + Choice program by reducing the extent to which the capitation rate depends upon the managed care organization's geographic area.

Under the Medicare + Choice program, the capitation rate is the greatest of three possible amounts: (1) a "blended" capitation rate (described below); (2) a minimum monthly payment, which in 1998 was $367; or (3) a minimum increase of two percent over the previous year's capitation rate. 42 U.S.C. 1395w-23(c)(1) (Supp. V 1999); 42 C.F.R. 422.252.

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[1] As an alternative, the managed care organization could return the savings to Medicare. 42 U.S.C. 1395mm(g)(2). But as the complaint explains, most managed care organizations opted to pass their savings along to beneficiaries. See Pet. App. 8c.

[2] Existing cost contracts have been allowed to continue. 42 U.S.C. 1395mm(h)(5) (Supp. V 1999).

The blended capitation rate is the sum of a percentage of an area-specific capitation rate that is based on the AAPCC, and a percentage of the national average Medicare capitation rate. 42 U.S.C. 1395w-23(c)(1)(A) (Supp. V 1999). The relative percentages vary over the six-year period in which the blended rate is implemented. 42 U.S.C. 1395w-23(c)(2) (Supp. V 1999). In the year 2000, for example, the area-specific percentage was 74% and the national percentage was 26%. 42 U.S.C. 1395w-23(c)(2)(C) (Supp. V 1999). After the year 2002, the area-specific and the national percentages will be 50% each. 42 U.S.C. 1395w-23(c)(2)(F) (Supp. V 1999). Thus, while the BBA provisions governing the Medicare + Choice program did not abandon the old AAPCC rates entirely, the new rates were designed to narrow, over time, the amount of payment variation across the country.[3]

As under the Section 1876 risk contracts, a managed care organization with a risk contract under the Medicare + Choice program is required to pass any "savings" along to beneficiaries, by providing additional benefits or reductions in enrollee premiums or cost-sharing in an amount equal to the difference between its ACR and the Medicare payment rate. 42 U.S.C. 1395w-24(f)(1) (Supp. V 1999); 42 C.F.R. 422.312.

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[3] The blended rate did not have an immediate impact, because the blended rate is adjusted by a budget neutrality factor designed to ensure that Medicare's aggregate payment under that rate equals the amount that Medicare would have paid under the AAPCC rate alone. 42 U.S.C. 1395w-23(c)(5) (Supp. V 1999). In the years 1998 and 1999, the budget neutrality factor reduced the blended rate to the point where no county's payment rate was based upon the blended rate, because one of the two other rates was higher in every county. 63 Fed. Reg. at 35,005.

2. Petitioner Mary Sarno is a Medicare beneficiary enrolled with a managed care plan under the Medicare + Choice program. The complaint alleges that she would like to move from Broward County, Florida to Minnesota, but that she has not moved because her health care coverage in Minnesota would be far less comprehensive than her coverage in Broward County, and would be insufficient to meet her health care needs. Pet. App. 4c-5c.

The complaint also alleges that the Medicare + Choice formula used for reimbursing managed care organizations with risk contracts does not bear a rational relationship to a legitimate governmental purpose and thus violates the equal protection component of the Fifth Amendment. Pet. App. 16c. The complaint further alleges that the reimbursement formula violates Sarno's constitutional right to travel because the geographic funding disparities it creates have deterred her from moving to Minnesota. *Id.* at 17c.[4]

3. The district court granted the government's motion to dismiss the complaint. Pet. App. 1b-27b. The court held that the Medicare + Choice reimbursement formula is rationally related to Congress's legitimate goals of containing Medicare costs and expanding health care delivery options. *Id.* at 17b. The court explained that the reimbursement formula contains costs by ensuring that Medicare does not pay more to managed care organizations than it pays in the same county under the traditional fee-for-service system. *Ibid.* The court recognized that the reimbursement

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[4] The State of Minnesota alleged in district court that the Medicare + Choice reimbursement formula violated Tenth Amendment rights. Pet. App. 13c-16c. The district court rejected that claim, *id.* at 10b-16b, and the State did not appeal, *id.* at 2a.

formula sometimes results in payment rates that vary geographically and that do not precisely reflect a managed care organization's actual costs. *Id.* at 20b. The court explained, however, that those variations are a result of geographic differences in the historical fee-for-service costs. See *ibid.* The court rejected as untenable the suggestion that Congress acted irrationally in relying on those historical numbers as a basis for the reimbursement formula. See *ibid.*

The court likewise rejected the contention that the Medicare + Choice reimbursement formula violates Sarno's constitutional right to travel. The court explained that the right to travel "protects the right of a citizen of one State to enter and to leave another State, the right to be treated as a welcome visitor rather than an unfriendly alien when temporarily present in the second State, and, for those travelers who elect to become permanent residents, the right to be treated like other citizens of that State." Pet. App. 22b (quoting *Saenz* v. *Roe*, 526 U.S. 489, 500 (1999)). The court held that the Medicare + Choice reimbursement formula implicates none of those principles. The court explained that, unlike the durational residency requirement at issue in *Saenz*, the reimbursement formula does not distinguish between long-term and new residents. See *id.* at 24b. The court explained that the second component of the right to travel as articulated in *Saenz* does not apply because Sarno does not seek to be treated as a "welcome visitor" in Minnesota; rather, she seeks to become a permanent resident. *Ibid.* The court explained that the reimbursement formula does not pose an "actual obstacle" to Sarno's right to free interstate movement. *Id.* at 25b. Finally, the court declined "to expand the right to travel to fit this case based on a few citations to inapposite precedents." *Id.* at 26b.

4. The court of appeals affirmed. Pet. App. 1a-9a. The court rejected petitioners' equal protection claim for the reasons given by the district court, observing that it was neither irrational nor arbitrary for Congress to devise a payment formula based on local health care costs and then to encourage cost-efficient managed care providers to increase benefits for their Medicare enrollees. *Id.* at 5a-6a.

The court of appeals also rejected petitioner's right to travel claim, agreeing with the district court that the Medicare + Choice formula implicates none of the concerns identified in *Saenz*. Pet. App. 7a. The court rejected the contention that a federal program that fails to achieve national uniformity in the distribution of government benefits should be subject to strict scrutiny simply because the disuniformity may deter persons from moving from some States to others. *Id.* at 8a. The court noted that petitioners' theory would call into question a wide range of federal programs, includeing the Medicaid program, the Temporary Assistance to Needy Families (TANF) program, and numerous agricultural subsidies, all of which provide different benefit levels based upon regional price conditions. *Id.* at 8a n.4.

ARGUMENT

The decision below is correct and does not conflict with a decision from any other court of appeals. The petition should therefore be denied.

1. Petitioners have abandoned their equal protection challenge to the Medicare + Choice formula, implicitly recognizing that the formula rationally serves Congress's goals of containing Medicare costs while expanding health care delivery options. Although petitioners press their right to travel claim, they do not

suggest that the Medicare + Choice formula implicates the concerns identified in *Saenz*.

Instead, petitioners urge (Pet. 11) that the right to travel should be expanded to require strict scrutiny of any federal program that discourages interstate migration. Petitioners rely on dicta from the plurality opinion in *Attorney General of New York* v. *Soto-Lopez*, 476 U.S. 898, 903 (1986), that stated that a law "implicates the right to travel when it actually deters such travel." Like the California law at issue in *Saenz*, however, the New York law at issue in *Soto-Lopez* implicated right to travel principles because it distinguished between two classes of state residents. The New York law gave civil service preference to residents whose military service post-dated their move to New York but denied such a preference to residents whose military service pre-dated their move to New York. The *Soto-Lopez* decision thus provides no support for the unprecedented expansion of right to travel principles that petitioners propose, an expansion that would call into question numerous federal programs. See Pet. App. 8a; see also *Saenz*, 526 U.S. at 493 (recognizing that the TANF program produces significant geographic variations in benefits, without suggesting that those variations implicate the right to travel).

2. Petitioners also argue (Pet. 11-15) that certiorari should be granted to resolve whether the right to travel equally applies to state and federal laws. The court of appeals, however, did not hold that the right to travel does not apply to federal laws. Rather the court of appeals rejected as "clearly too broad" petitioners' argument "that a federal program that fails to achieve nationwide uniformity in the distribution of government benefits is subject to strict scrutiny because it will deter travel to unfavored locales." Pet. App. 8a.

Petitioners cite no decision adopting such an expansive view of the right to travel, and we are not aware of any. It would, for example, be wholly implausible for petitioners to suggests that the States are constitutionally required to provide their residents with all categories of benefits that any sister State chooses to provide to its residents, let alone that the benefits must be provided to an identical degree.[5]

Petitioners are also incorrect in suggesting (Pet. 13-15) that the decision below conflicts with *Bethesda Lutheran Homes & Services, Inc.* v. *Leean*, 122 F.3d 443 (7th Cir. 1997). The court in *Bethesda Lutheran* invalidated a Wisconsin law and federal Medicaid regulations because those provisions prevented mentally incompetent persons from becoming Wisconsin residents and receiving any benefits under Medicaid. See *id.* at 448. Petitioners do not allege that the Medicare + Choice formula prevents Sarno from becoming a Minnesota resident or obtaining Medicare benefits; they assert only that differential Medicare benefits makes Minnesota residency less attractive to her. The courts below correctly found no unconstitutional infirmity in that result, and further review by this Court is unwarranted.[6]

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[5] Petitioners therefore err in suggesting (Pet. 16-20) that this Court should grant review in order to consider the source and contours of the right to travel.

[6] Because petitioners do not state a cognizable constitutional claim, they are further incorrect in arguing (Pet. 21-22) that they should be afforded an opportunity to take discovery to adduce proof that the challenged Medicare provisions deter interstate relocation.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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No. 01-1372

In the Supreme Court of the United States

MINNESOTA SENIOR FEDERATION, METROPOLITAN REGION; and MARY SARNO,

Petitioners,

v.

UNITED STATES OF AMERICA; and TOMMY G. THOMPSON, Secretary of Health and Human Services,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

PETITIONERS' REPLY BRIEF

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In their Brief in Opposition, Respondents fault Petitioners for "not suggest(ing) that the Medicare+Choice reimbursement formula implicates the concerns identified" in Saenz v. Roe, 526 U.S. 489 (1999). Resp. Opp. Br. 9-10. The Saenz decision, however, is not an explication of all aspects of the constitutional right to travel. (Pet. 12-13) The components described in Saenz do not cover, for example, cases holding that the right to travel protects against restrictions on international travel. See, e.g., Aptheker v. Secretary of State, 378 U.S. 500 (1964). Saenz focussed on *state* restrictions and did not concern – as does this case – a federal statutory regime and program applicable *nationwide*, which may call for somewhat different analysis, comparisons, or standards. (Pet. 19-20) Respondents also attempt to distinguish Attorney General of New York v. Soto-Lopez, 476 U.S. 898 (1986), on its facts (Resp. Opp. Br. 10). However, Petitioners cited Soto-Lopez, not for any factual congruity with the present case, but for its summary of the right to travel and its statement of the fundamental principle that a law "implicates the right to travel when it actually deters such travel." Id. at 903 (Pet. 11). Soto-Lopez has been frequently cited for that proposition. See, e.g., Kansas v. United States, 16 F.3d 436, 441-42 (D.C. Cir. 1994) (recognizing the Soto-Lopez principle and finding the deterrent effect of the Wright Amendment, the particular federal statute involved, on interstate travel – air travel to and from the Dallas-Ft. Worth area – to be negligible).

Petitioners request that the Court clarify the source and nature of the right to travel and its application to federal laws (i.e., the analysis to be employed, and whether it is identical to or different from the analysis employed in cases involving state laws). A different analysis, comparisons, or standards may be called for with respect to federal laws and programs imposed nationwide (where the federal government is able to apply requirements and benefits uniformly) and with respect

to state laws and programs that are applicable statewide and are imposed by entities that do not have authority to legislate or regulate in other states. Respondents – attacking a straw man – contend that it would be wholly implausible for Petitioners to suggest (they do not) that a state is constitutionally required to provide to its residents all categories and amounts of benefits that any other state chooses to provide. (Resp. Opp. Br. 11) This is no argument against a timely clarification of right-to-travel analysis to be applied in cases involving statutes and programs applicable *nationwide*.

Respondents argue that, in Bethesda Lutheran Homes and Servs., Inc. v. Leean, 122 F.3d 443 (7th Cir. 1997), the Seventh Circuit invalidated a state law and related federal Medicaid provisions because they "prevented" the plaintiffs from becoming Wisconsin residents and receiving Medicaid benefits, while Petitioners in the present case do not allege that the federal Medicare provisions "prevent" plaintiff Sarno from becoming a Minnesota resident, only that Medicare benefit differences make Minnesota residency "less attractive." (Resp. Opp. Br. 11) Respondents are wrong on both points. In Bethesda Lutheran, the Seventh Circuit said that the "Medicaid regulations *make it difficult* for indigent incompetent nonresidents to obtain institutional care in Wisconsin" (122 F.3d at 448, emphasis added) and that the regulations "do not forbid anyone to change his state of residence," but rather, impose a "monetary penalty" on indigents who move from one state to another. Ibid. The Seventh Circuit found this to be an infringement of the right to travel, which – under Shapiro v. Thompson, 394 U.S. 618 (1969), and other decisions – must be justified. Ibid. In the present case, Petitioners specifically allege that the Medicare formula at issue "penalizes some seniors for exercising their right to travel" and that plaintiff Sarno "is deterred from and would be penalized for moving from Florida to Minnesota."

(C-17) Respondents' attempt to explain away the conflict of the Eighth Circuit's decision in this case with the Seventh Circuit's decision in Bethesda Lutheran on the basis that the latter involved regulations that "prevented" an interstate move, while this case involved regulations that merely make an interstate move "less attractive" is ill-founded and without merit. Whatever descriptive words are used, both cases involve burdens upon or impediments to interstate travel and relocation, and the two Courts of Appeals employed different, conflicting analyses.

Respondents raise the specter that Petitioners' theory "would call into question a wide range of federal programs. . . which provide different benefit levels based on regional price conditions." (Resp. Opp. Br. 9) But no other program is at issue or before the Court. Whether some other federal program might be drawn into question by a similar analysis would depend on its specific provisions and the relevant facts. If, for example, a particular program provided different amounts of benefits to participants in different geographic locations that left the participants in the same *net position* (e.g., because one receiving more benefits had greater costs), neither would have an inducement to change or to refrain from changing locations, and the right to travel would not be implicated. That is not the situation of Medicare HMO participants under the Medicare+Choice formula here at issue. A Florida participant receives substantially greater *net benefits* than a Minnesota participant, impairing and interfering with participant relocation from the former state to the latter. Allusions to possible cases not before the Court should not divert the Court from the issue presented.

CONCLUSION

On the basis of the matters set forth in the Petition and in the foregoing Reply Brief, the Petition for a Writ of Certiorari should be granted.

Respectfully submitted,

Dated: June 6, 2002

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